HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING JUNE 27, 2018 APPLICATION SUMMARY

NAME OF PROJECT:

Crestwyn Behavioral Health

PROJECT NUMBER:

CN1803-018

ADDRESS:

9485 Crestwyn Hills Cove

Germantown (Shelby County), TN 38125

LEGAL OWNER:

Crestwyn Health Group, LLC

c/o Acadia Healthcare

6100 Tower Circle, Suite 1000

Franklin (Williamson County), TN 37067

OPERATING ENTITY:

N/A

CONTACT PERSON:

John Wellborn

(615-665-2022)

DATE FILED:

March 15, 2018

PROJECT COST:

\$91,000.00

FINANCING:

Cash Reserves

REASON FOR FILING:

The addition of 14 inpatient psychiatric beds to an

existing 66 bed mental health hospital

DESCRIPTION:

Crestwyn Behavioral Health (Crestwyn) is seeking approval for the addition of 14 psychiatric inpatient beds to its existing 66 bed mental health hospital. The existing 66 licensed beds consist of 33 adult psychiatric beds, 16 child/adolescent beds, and 17 adult dual diagnosis/substance abuse beds. The project proposes to increase total licensed beds to 80 beds. The adult beds will be increased to 36 beds (increase of 3), the child/adolescent beds will be increased to 32 beds (increase of 16). The dual diagnosis/substance abuse beds will be reduced from 17 beds to 12 beds (decrease of 5). All bed increases will be in existing semi-private size patient rooms that are currently used as single rooms. The project

does not involve any construction. If approved, the applicant plans to initiate service on August 27, 2018.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW:

Psychiatric Inpatient Services

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).

See below

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

3. SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

Psychiatric Inpatient Services

Standards and Criteria

1. Determination of Need: The population-based estimate of the total need for psychiatric inpatient services is a guideline of 30 beds per 100,000 general population, using population estimates prepared by the TDH and applying the applicable data in the Joint Annual Report (JAR). These estimates represent gross bed need and shall be adjusted by subtracting the existing applicable staffed beds

including certified beds in outstanding CONs operating in the area as counted by the TDH in the JAR. For adult programs, the age group of 18-64 years shall be used in calculating the estimated total number of beds needed; additionally, if an applicant proposes a geriatric psychiatric unit, the age range 65+ shall be used. For child inpatients, the age group is 12 and under, and if the program is for adolescents, the age group of 13-17 shall be used. The HSDA may take into consideration data provided by the applicant justifying the need for additional beds that would exceed the guideline of 30 beds per 100,000 general population. Special consideration may be given to applicants seeking to serve child, adolescent, and geriatric inpatients. Applicants may demonstrate limited access to services for these specific age groups that supports exceeding the guideline of 30 beds per 100,000 general population. An applicant seeking to exceed this guideline shall utilize TDH and TDMHSAS data to justify this projected need and support the request by addressing the factors listed under the criteria "Additional Factors".

Service Area	Populat	ion 2020	Gross Nee (30 beds/	•	Current	: Beds	Net f	Need
	C & A 0-17	Adult 18+	C & A 0-17	Adult 18+	C & A 0-17	Adult 18+	C & A 0-17	Adults 18+
Shelby County	252,312	728,710	76	219	140	604	(64) Surplus	(385) Surplus
*Secondary Service Area	148,338	531,674	45	160	0	278	45 Need	(118)
Total	400,650	1,260,384	120	378	140	882	(20)	(504)

*Secondary service areas in Tennessee, Arkansas, and Mississippi include: Benton, Benton MS, Carroll, Chester, Crittenden AR, Crockett, Decatur, Desoto MS, Dyer, Fayette, Lake, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Fayette, Lauderdale, Lawrence AR, Madison, Marshall MS, McNairy, Obion, and Tipton counties.

According to the TDMHSAS Report, there are 140 inpatient psychiatric beds in the primary service area for ages 0-17. The psychiatric bed formula indicates a 2020 psychiatric bed surplus of (64) beds for ages 0-17 in the primary service area of Shelby County and a net bed need of 45 beds in the secondary Service Area consisting of the following counties in Arkansas, Mississippi, and Tennessee: Benton (TN), Benton (MS), Carroll (TN), Chester (TN), Crittenden (AR), Crockett (TN), Decatur (TN), Desoto (MS), Dyer (TN), Fayette (TN), Lake (TN), Gibson (TN), Hardeman (TN), Hardin (TN), Haywood (TN), Henderson (TN), Henry (TN), Fayette (TN), Lauderdale (TN), Lawrence (AR), Madison (TN), Marshall (MS), McNairy (TN), Obion (TN), and Tipton (TN) Counties. When applying the bed formula to both Shelby County and the Secondary Service Area, the psychiatric bed formula indicates a year 2020 psychiatric bed surplus of (20) beds for ages 0-17.

According to the TDMHSAS Report, there are 604 inpatient psychiatric beds in the primary service area for ages 18+. The psychiatric bed formula indicates a 2020 psychiatric bed surplus of (385) beds for ages 18+ in the primary service area of Shelby County and a bed surplus of (118) beds in the secondary Service Area consisting of the following counties in Arkansas, Mississippi, and Tennessee: Benton (TN), Benton (MS), Carroll (TN), Chester (TN), Crittenden (AR), Crockett (TN), Decatur (TN), Desoto (MS), Dyer (TN), Fayette (TN), Lake (TN), Gibson (TN), Hardeman (TN), Hardin (TN), Haywood (TN), Henderson (TN), Henry (TN), Fayette (TN), Lauderdale (TN), Lawrence (AR), Madison (TN), Marshall (MS), McNairy (TN), Obion (TN), and Tipton (TN) Counties. When applying the bed formula to both Shelby County and the Secondary Service Area, the psychiatric bed formula indicates a 2020 gross psychiatric bed surplus of (504) beds for ages 18+.

When considering the 0-17 age group, it appears that this criterion <u>has not been met</u> for the primary service area, but <u>met</u> for the Tennessee secondary service area. The 0-17 adult bed surplus is (64) in Shelby County and a net need of 45 in the secondary service area resulting in a (20) bed surplus in the total proposed service area.

When considering the 18+ age group, it appears that this criterion <u>has not been met</u> for the primary and secondary service area. The 18+ adult bed surplus is (385) in Shelby County and (118) in the secondary service area resulting in a (504) bed surplus in the total proposed service area.

- **2. Additional Factors:** An applicant shall address the following factors:
- **a.** The willingness of the applicant to accept emergency involuntary and nonemergency indefinite admissions;

The applicant accepts involuntary admissions.

b. The extent to which the applicant serves or proposes to serve the TennCare population and the indigent population;

In Year One the payor mix is 46.3% TennCare (\$1,918,769) and 0.9% (\$37,298) Charity Care.

c. The number of beds designated as "specialty" beds (including units established to treat patients with specific diagnoses);

Not applicable.

d. The ability of the applicant to provide a continuum of care such as outpatient, intensive outpatient treatment (IOP), partial hospitalization, or refer to providers that do;

The applicant offers IOP and partial hospitalization psychiatric care.

It appears that this criterion has been met.

e. Psychiatric units for patients with intellectual disabilities;

The applicant does not provide services to patients with intellectual disabilities (ID).

f. Free standing psychiatric facility transfer agreements with medical inpatient facilities;

The applicant has transfer agreements with Baptist affiliated inpatient hospitals and Saint Francis Hospital both located in Shelby County.

g. The willingness of the provider to provide inpatient psychiatric services to all populations (including those requiring hospitalization on an involuntary basis, individuals with co-occurring substance use disorders, and patients with comorbid medical conditions); and

The applicant provides shore-term acute inpatient care to patients requiring hospitalization on an involuntary basis, and individuals with co-occurring substance abuse issues. The applicant transfers to Baptist Hospital (Shelby County) for patients who require acute inpatient medical care.

h. The applicant shall detail how the treatment program and staffing patterns align with the treatment needs of the patients in accordance with the expected length of stay of the patient population.

The applicant will staff its treatment programs in accordance with the acuity of its patients and their expected lengths of stay.

i. Special consideration shall be given to an inpatient provider that has been specially contracted by the TDMHSAS to provide services to uninsured patients in a region that would have previously been served by a state operated mental health hospital that has closed.

Not applicable to the proposed service area.

j. Special consideration shall be given to a service area that does not have a crisis stabilization unit available as an alternative to inpatient psychiatric care.

The Shelby County primary service area has two crisis stabilization units: Southeast Mental Health Center (15 beds) and Lakeside Behavioral Health System (8 beds). The secondary service area has one crisis stabilization unit (15 bed) located at Pathways in Jackson (Madison County), TN.

3. Incidence and Prevalence: The applicant shall provide information on the rate of incidence and prevalence of mental illness and substance use within the proposed service area in comparison to the statewide rate. Data from the TDMHSAS or the Substance Abuse and Mental Health Services Administration (SAMHSA) shall be utilized to determine the rate. This comparison may be used by the HSDA staff in review of the application as verification of need in the proposed service area.

The applicant utilized data from the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) Behavioral Health Prepalence Deckhoord which indicated the following:

Prevalence Dashboard which indicated the following:

2012-2014	Region 6 (24 West TN Counties) %	Shelby County	Tennessee %	U.S.
18+ Any Mental Illness in the past year	20.1%	19.1%	20.3%	18.4%
18+ Serious Mental Illness in the past year	4.6%	3.8%	4.5%	4.1%

Source: TDMHSAS Web-site, Years 2012-2014

It appears that this criterion has been met.

Note to Agency members: HSDA staff researched data from the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) web-site which indicated the following number of admissions and rate per 1,000 population for the 18+ population that were admitted to TDMHSAS-funded regional mental health institutes and private psychiatric hospitals that contract with TDMHSAS.

Area	Admission Rate per 1,000	# of
	Adults 18+	Admissions
State of Tennessee	2.3	12,284
Region 6 (20 West TN Counties)	1.7	959
Shelby (Primary Service Area)	2.1	1,485

Source: TDMHSAS, 2017 Behavioral Health County and Region Services Data Book, Page 64, Table 44A.

As reflected above, Shelby County is below the statewide admission rate of 2.3 per 1,000 population for the 18+ population in 2016. In the secondary service area Region 6's rate of 1.7 per 1,000 was also below the statewide rate of 2.3 per 1,000.

4. Planning Horizon: The applicant shall predict the need for psychiatric inpatient beds for the proposed first two years of operation.

The applicant provided projections for CY2020 and CY 2022. The applicant projected a licensed bed surplus of 273 beds in 2020 and 264 beds in 2022 for the combined primary and secondary service areas.

5. Establishment of Service Area: The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The proposal's sensitivity and responsiveness to the special needs of the service area shall be considered, including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, other medically underserved populations, and those who need services involuntarily. The applicant may also include information on patient origination and geography and transportation lines that may inform the determination of need for additional services in the region.

The applicant is an existing freestanding psychiatric hospital with an established service area and payor mix.

6. Composition of Services: Inpatient hospital services that provide only substance use services shall be considered separately from psychiatric services in a CON application; inpatient hospital services that address co-occurring substance use/mental health needs shall be considered collectively with psychiatric services. Providers shall also take into account concerns of special populations (including, e.g., supervision of adolescents, specialized geriatric, and patients with comorbid medical conditions).

The composition of population served, mix of populations, and charity care are often affected by status of insurance, TennCare, Medicare, or TriCare; additionally, some facilities are eligible for Disproportionate Share Hospital payments based on the amount of charity care provided, while others are not. Such considerations may also result in a prescribed length of stay.

In Year One the payor mix is 46.3% *TennCare* (\$1,918,769) *and* 0.9% (\$37,298) *Charity Care.*

7. Patient Age Categorization: Patients should generally be categorized as children (0-12), adolescents (13-17), adults (18-64), or geriatrics (65+). While an adult inpatient psychiatric service can appropriately serve adults of any age, an applicant shall indicate if they plan to only serve a portion of the adult population so that the determination of need may be based on that age-limited population. Applicants shall be clear regarding the age range they intend to serve; given the small number of hospitals who serve younger children (12 and under), special consideration shall be given to applicants serving this age group. Applicants shall specify how patient care will be specialized in order to appropriately care for the chosen patient category.

The applicant primarily serves patients ages 13 and above who are appropriate for psychiatric care. The applicant does not routinely serve children 12 years of age or younger, however, Crestwyn has admitted 10-12 year old children as special cases at the request of TennCare.

8. Services to High-Need Populations: Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are involuntarily committed, uninsured, or low-income.

The applicant accepts involuntary admissions (20.6% in 2017). In Year One, the applicant anticipates providing 46.3% TennCare (\$1,918,769) and 0.9% (\$37,298) Charity Care.

It appears that this criterion <u>has been met.</u>

9. Relationship to Existing Applicable Plans; Underserved Area and Populations: The proposal's relationships to underserved geographic areas and underserved population groups shall also be a significant consideration. The impact of the proposal on similar services in the community supported by state appropriations shall be assessed and considered; the applicant's proposal as to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility

serves acute and/or long-term patients, shall also be assessed and considered. The degree of projected financial participation in the Medicare and TennCare programs shall be considered.

As previously noted, the applicant will accept involuntary admissions. In Year One, the applicant anticipates providing 22.5% Medicare (\$932,447), 46.3% TennCare (\$1,918,769), and 0.9% (\$37,298) Charity Care.

It appears that this criterion <u>has been met.</u>

Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall also include how the applicant's services may differ from existing services (e.g., specialized treatment of an age-limited group, acceptance of involuntary admissions, and differentiation by payor mix). Accessibility to specific special need groups shall also be discussed in the application.

The applicant provided occupancy and utilization of other licensed mental health hospitals and psychiatric units of general hospitals in Section-B-Need-5 of the application.

It appears that this criterion has been met.

10. Expansion of Established Facility: Applicants seeking to add beds to an existing facility shall provide documentation detailing the sustainability of the existing facility. This documentation shall include financials, and utilization rates. A facility seeking approval for expansion should have maintained an occupancy rate for all licensed beds of at least 80 percent for the previous year. The HSDA may take into consideration evidence provided by the applicant supporting the need for the expansion or addition of services without the applicant meeting the 80 percent threshold. Additionally, the applicant shall provide evidence that the existing facility was built and operates, in terms of plans, service area, and populations served, in accordance with the original project proposal.

The applicant indicates in 2017 the occupancy on the three psychiatric programs seeking to expand was 87.5%. The applicant's projected Data Chart indicates the Free Cash Flow (Net Balance + Depreciation) for the applicant will equal \$1,321,015 in Year One increasing to \$1,549,733 in Year Two.

It appears that this criterion has been met.

11. Licensure and Quality Considerations: Any existing applicant for this CON

service category shall be in compliance with the appropriate rules of the TDH and/or the TDMHSAS. The applicant shall also demonstrate its accreditation status with the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or other applicable accrediting agency. Such compliance shall provide assurances that applicants are making appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space). Applicants shall also make appropriate accommodations so that patients are separated by gender in regards to sleeping as well as bathing arrangements. Additionally, the applicant shall indicate how it would provide culturally competent services in the service area (e.g., for veterans, the Hispanic population, and LBGT population).

The applicant is accredited by The Joint Commission. Patients will receive culturally competent services. Translation services will be available. Seclusion rooms are provided and appropriate age and gender separations are observed.

It appears that this criterion has been met.

12. Institution for Mental Disease Classification: It shall also be taken into consideration whether the facility is or will be classified as an Institution for Mental Disease (IMD). The criteria and formula involve not just the total number of beds, but the average daily census (ADC) of the inpatient psychiatric beds in relation to the ADC of the facility. When a facility is classified as an IMD, the cost of patient care for Bureau of TennCare enrollees aged 21-64 will be reimbursed using 100 percent state funds, with no matching federal funds provided; consequently, this potential impact shall be addressed in any CON application for inpatient psychiatric beds.

The applicant will be designated as an IMD since the applicant will be primarily serving TennCare enrollees ages 21-64.

13. Continuum of Care: Free standing inpatient psychiatric facilities typically provide only basic acute medical care following admission. This practice has been reinforced by Tenn. Code Ann. § 33-4-104, which requires treatment at a hospital or by a physician for a physical disorder prior to admission if the disorder requires immediate medical care and the admitting facility cannot appropriately provide the medical care. It is essential, whether prior to admission or during admission that a process be in place to provide for or to allow referral for appropriate and adequate medical care. However, it is not effective, appropriate, or efficient to provide the complete array of medical services in an inpatient psychiatric setting.

If needed, patients will be referred to Baptist and St. Francis affiliated hospitals in Shelby County for medical care.

14. Data Usage: The TDH and the TDMHSAS data on the current supply and utilization of licensed and CON-approved psychiatric inpatient beds shall be the data sources employed hereunder, unless otherwise noted. The TDMHSAS and the TDH Division of Health Licensure and Regulation have data on the current number of licensed beds. The applicable TDH JAR provides data on the number of beds in operation. Applicants should utilize data from both sources in order to provide an accurate bed inventory.

The applicant utilized existing TDH and TDMHSAS data in the preparation of the application.

It appears that this criterion has been met.

15. Adequate Staffing: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed Service Area. Each applicant shall outline planned staffing patterns including the number and type of physicians. Additionally, the applicant shall address what kinds of shifts are intended to be utilized (e.g., 8 hour, 12 hour, or Baylor plan). Each unit is required to be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times. This staffing level is the minimum necessary to provide safe care. The applicant shall state how the proposed staffing plan will lead to quality care of the patient population served by the project.

However, when considering applications for expansions of existing facilities, the HSDA may determine whether the existing facility's staff would continue without significant change and thus would be sufficient to meet this standard without a demonstration of efforts to recruit new staff.

The project will require an additional 8.13 direct patient care FTEs. The applicant attested that all licensing and accrediting agency staffing requirements will be met. A staffing table is located on page 62R of the application.

It appears that this criterion has been met.

16. Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/ services and working agreements with other related community services assuring continuity of care (e.g., agreements between freestanding

psychiatric facilities and acute care hospitals, linkages with providers of outpatient, intensive outpatient, and/ or partial hospitalization services). If they are provided, letters from providers (e.g., physicians, mobile crisis teams, and/or managed care organizations) in support of an application shall detail specific instances of unmet need for psychiatric inpatient services. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

The applicant has a community linkage plan which connects patients to the appropriate available resource upon discharge.

It appears that this criterion has been met.

17. Access: The applicant must demonstrate an ability and willingness to serve equally all of the patients related to the application of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed service area.

The applicant notes the historic Crestwyn payor mix documents it accessibility to the general patient population, including low-income and elderly persons, and patients needing involuntary admission.

It appears that this criterion has been met.

18. Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. An applicant that owns or administers other psychiatric facilities shall provide information on their surveys and their quality improvement programs at those facilities, whether they are located in Tennessee or not.

The applicant will report required data to HSDA. The applicant has existing data reporting, quality improvement, and outcome and process monitoring systems. Acadia (managing entity of the applicant) is affiliated with four existing psychiatric hospitals in Tennessee and has included their surveys in the attachments.

It appears that this criterion has been met.

19. Data Requirements: Applicants shall agree to provide the TDH, the TDMHSAS, and/ or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

The applicant agrees to provide all reasonably requested information.

It appears that this criterion has been met.

STAFF SUMMARY

Note to Agency members: This staff summary is a synopsis of the original application and supplemental responses submitted by the applicant. Any HSDA Staff comments will be presented as a "Note to Agency members" in bold italic.

Application Synopsis

As previously indicated, Crestwyn proposes to add fourteen beds to its 66-bed mental health hospital in Germantown, Tennessee. Crestwyn is a joint venture involving its corporate parent, Acadia Healthcare, Baptist Memorial Healthcare, and Saint Francis Hospital. Acadia owns Delta Medical Center, a 243 bed general hospital in Shelby County that provides both acute and psychiatric services, and the controlling interest in Crestwyn LLC.

Crestwyn is designated as an IMD (Institution for Mental Disease). When a facility is classified as an IMD, the cost of patient care for TennCare enrollees aged 21-64 is reimbursed using all state funds, with no matching federal funds.

*Note to Agency Members: An Institution for Mental Diseases (IMD) is currently defined as "a hospital, nursing facility or other institution of more than 16-beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services" (42 C.F.R. §435.1010). According to a May 18, 2018 email from a representative of TennCare, federal funds are now allowed to be used up to 15 days per month for an inpatient stay in an IMD, which should cover almost all private IMD stays.

Background Information: Previously, Medicaid funding was not available to, or for the benefit of, Medicaid beneficiaries living in facilities that have been determined to be IMDs. According to NAMI (National Alliance on Mental Illness) and the National Association for Children's Behavioral Health, the IMD exclusion has been in place since 1965 when Medicaid was enacted. It originally excluded federal funding for any services provided to an individual who was under age 65 and was a patient in an Institute of Mental Disease. State and local psychiatric hospitals housed large numbers of persons with severe mental illness at (non-federal) public expense. The Congress made clear that the new Medicaid dollars were not to supplant this public effort that was already going on with resources from state and local governments. The federal matching funds exclusion was narrowed in 1972 when an exception was established for individuals under age 21. In 1988, Congress defined an IMD as a facility with

more than 16 beds. While the Affordable Care Act expanded mental health coverage, it did not eliminate the IMD exclusion.

The projected completion date of the proposed project is October 2018.

Facility Information

- The Crestwyn Behavioral Health facility is a 61,592 SF one story building located on 33.8 acres.
- If approved, the facility will consist of two adolescent units consisting of 20 beds and 12 beds, and two adult units consisting of one 20 adult unit and one 28 bed adult unit.
- One wing of the facility is dedicated to adolescent care, while the other wing is dedicated to adult care. A nursing station is strategically located in each wing that provides a line of view of all patient rooms.
- Each of the four units has activity rooms, comfort and seclusion rooms, support spaces and staff offices.

Ownership

- Crestwyn Behavioral Health is a joint venture between Acadia Healthcare Inc. (60%), and two Shelby County hospitals, Baptist Memorial Health Services Inc. (20%), and Saint Francis Hospital (SFH).
- SFH is wholly owned by Tenet Healthcare headquartered in Dallas, Texas.
- Acadia Healthcare is a publicly traded national behavioral healthcare company. A table of four Tennessee hospitals affiliated with Acadia and percentage of ownership is located on page 2 of supplemental #1.

History

- Crestwyn Behavioral Health (CN1310-040A) was approved at the April 23, 2014 Agency meeting for the establishment of a new 60 bed mental health hospital consisting of 15 inpatient beds for psychiatric care for adolescents ages 13-17, 15 inpatient beds for adult psychiatric care for adults ages 18-64, 15 inpatient beds for geropsychiatric care for ages 65+, and 15 adult chemical dependency beds.
- In the CON application, Delta agreed to reduce its licensed psychiatric bed complement by 20 beds, and Saint Francis, a 519 bed general hospital that also provides both acute and psychiatric beds, agreed to de-license 40 psychiatric beds for a total of 60 beds if the application was approved.
- 6 beds were added (May 2017) via the 10% exclusion allowed by P.C. 1043

NEED

Project Need

The applicant provides the following justification in the original application:

- The proposed project will allow the dual diagnosis beds to operate at a higher efficiency (almost 87% in Year Four, CY 2022) and provide room for program growth in adult and adolescent programs.
- The bed increase and reassignment of beds will allow Crestwyn (that operates at more than 90% occupancy) to double its complement of child and adolescent beds that will in turn relieve the daily shortages of child/adolescent beds.
- The applicant operates with a payor mix of 48% that includes TennCare, self-pay, and charity care that is needed in the community.
- The need is supported by mental health care providers and organizations that have identified the need for additional inpatient capacity.

Service Area Demographics

Primary Service Area

Crestwyn Behavioral Health's declared primary service area is Shelby County.

Total Population

Primary Service Area

- The total population of the primary service area is estimated at 970,212 residents in calendar year (CY) 2018 increasing by approximately 1.1% to 981,022 residents in CY 2020.
- The total population of the state of Tennessee is expected to grow 2.2% during the same timeframe.

0-17 Population

- The total 0-17 population is estimated at 249,747 residents in 2018 increasing approximately 1.0% to 252,312 residents in 2020.
- The age 0-17 population in the State of Tennessee overall is expected to increase 1.4% during the same timeframe.

18-64 Population

- The total 18-64 population is estimated at 844,823 residents in 2018 increasing approximately by 0.11% to 845,788 in 2020.
- The total 18-64 population in the State of Tennessee overall is expected to increase by 1.8% during the same timeframe.

65+ Population

- The total 65+ age population is estimated at 125,389 residents in CY 2018 increasing approximately 7.9% to 135,234 residents in 2020. The 65+ age population in the state of Tennessee overall is expected to increase 7.8% during the same timeframe.
- The Age 65+ population in the primary service area is projected to equal 13.8% of the total population in 2020. This compares to 17.8% for the State of Tennessee overall.

TennCare Population

• The latest 2018 percentage of the primary service area population enrolled in the TennCare program is approximately 25.5%, as compared to the statewide enrollment proportion of 20.8%.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Secondary Service Area

The secondary service area consists of the following 20 Tennessee Counties: Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, McNairy, Madison, Obion, Tipton, and Weakley Counties.

• The total population of the Tennessee secondary service area is estimated at 671,922 residents in calendar year (CY) 2018 increasing by approximately 1.2% to 680,012 residents in CY 2020.

The out-of-state secondary service area counties include the following: Critenden (Arkansas), Lawrence (Arkansas), Desoto (Mississippi), Marshall (Mississippi), and Benton (Mississippi).

• The total population of the out-of-state secondary service area is estimated at 284,976 residents in calendar year (CY) 2018 increasing by approximately 1.7% to 289,717 residents in CY 2020.

Service Area Historical Utilization

Service Area Historical Utilization and Overall Market Share

Facility	County	Beds	2014	2015	**2016	′14-′16	2014	2015	2016
		(2016)	Patient	Patient	Patient	%	Occup	Occup.	Occup.
			Days	Days	Days	Change			
Crestwyn	Shelby	60	n/a	n/a	6,104	n/a	n/a	n/a	27.8%
Behavioral Health									
Lakeside Behavioral	Shelby	261/	81,505	83,731	85,388	+4.7%	85.6%	87.9%	*85.7%
Health System-		287							
Psych beds									
Memphis Mental	Shelby	111	16,877	17,299	17,565	+4.1%	41.7%	42.7%	43.4%
Health Institute	li .								
Delta Medical	Shelby	114	37,501	36,741	33,748	-10%	94.3%	92.3%	80.8%
Center							109 beds	109 beds	114 beds
Methodist University	Shelby	34	8,467	7,791	7,336	-13.4%	68.2%	62.8%	59.0%
Healthcare-psych									
beds	CI II		44.500	10.005	44 700	0.50/	20.00/	07.40/	10.0%
St. Francis Hospital	Shelby	80	11,502	13,825	11,790	+2.5%	30.9%	37.1%	40.3%
Psych beds		606	4 = = 0 = 0	450 005	4.64.004	. 2 (0)	102 beds	102 beds	80 beds
Shelby County		686	155,852	159,387	161,931	+3.6%	71.2%	72.3%	66% *660/686
Subtotal							600 beds	617 beds	beds
Baptist Memorial	Carroll	12	n/a	1,871	1,437	n/a	n/a	42.7%	32.7%
Huntington Hospital	Carron	1 12	11, 4	1,071	1,10,	11/ 4	11, 4	12., ,	02., 70
Western Mental	Hardeman	187	44,339	46,855	41,617	-6.1%	65%	68.6%	60.8%
Health Institute	2 2011 010111011		11,003	10,030	11/01/		33,3		
Henry County	Henry	22	2,189	2,097	2,257	+3.1%	27.3%	26.1%	28%
Medical Center			'	,	,				
Pathways of	Madison	25	3,706	3,245	3,304	-10.8%	40.6%	35.6%	36.2%
Tennessee			,	,					
Woodridge of West	Madison	16	n/a	n/a	3,475	n/a	n/a	n/a	59.3%
Tennessee dba Oak				,		i ' l	,		
Hills Behavioral									
Center								,	
Behavioral Center at	Weakley	16	4,274	3,455	3,557	-16.8%	73.2%	59.2%	60.7%
Martin									
TN Secondary	A STATE OF THE STATE OF	278	54,508	57,523	55,647	+2.1%	53.7%	56.6%	54.5%
Service Area	The second second			77 7 75 53 55 5				PART PROPERTY	
Subtotal						Burth SE		entra entra	
Grand Total		964	210,360	216,910	217,578	+3.4%	61.6%	63.6%	62.6%
(TN Primary +									
Secondary Service						Try long Di			
Area Totals)		HIELES					The state of the s		

Source: Tennessee Department of Health, Joint Annual Reports - 2014, 2015, and 2016

^{*}Lakeside added 26 beds in 2016 allowed under the 10% exemption provided in Chapter 1043. The 2016 occupancy is based on 261 licensed beds from January 1-July 26, 2016 and 287 beds from July 27, 2016 to December 31, 2016.

^{**2016} included 366 days due to leap year.

- The above chart indicates inpatient psychiatric utilization in the primary service area (Shelby County) increased 3.4% from 155,852 patient days in 2016 to 161,931 patient days in 2016.
- Inpatient psychiatric utilization in the secondary service area increased 2.1% from 54,508 patient days in 2014 to 55,647 patient days in 2016.
- Inpatient psychiatric utilization in the both the primary and secondary service area increased 3.4% from 210,360 patient days in 2014 to 217,578 patient days in 2016.
- Memphis University Healthcare (Shelby County) experienced the largest percentage decrease in psychiatric patient days in the primary service area from 2014 to 2016. Patient days decreased from 8,467 patient days in 2014, to 7,336 patient days in 2016, or -13.4%.
- Overall psychiatric bed occupancy in Shelby County has been in the 66-73% range during 2014-2016.
- Total service area occupancy increased from 61.6% in 2014 to 62.6% in 2016.

Applicant Historical and Projected Utilization

The applicant's historical and projected utilization for the first two years after project completion is presented in the following table.

Crestwyn Behavioral Health Projected Utilization Year One and Year Two

Variable	2017	2018	2019	2020
		(annualized)		
Total Beds	66	66	80	80
Admissions	1,724	2,004	2,275	2,404
Pat. Days	17,714	20,043	22,749	24,022
ALOS	10.3	10.0	10.0	10.0
ADC	48.5	52.3	62.3	65.6
Lic. Occ.	73.5%	83.2%	77.9%	82.0%
Ages 18+ Psych Licensed Beds	33 beds	33 beds	36 Beds	36 Beds
Ages 18+ Psych. Admissions	995	1149	1092	1103
Ages 18+ Psych. Pat. Days	10,469	11,724	11,138	11,249
Ages 18+ Psych ALOS	10.5	10.2	10.2	10.2
Ages 18+ Psych ADC	28.7	32.1	30.5	30.7
Ages 18+ % Lic. Occ.	86.9%	97.3%	84.8%	85.4%
Child and Adolescent Beds	16	16	32	32
Admissions	494	573	859	945
Pat. Days	5,179	5,840	8,760	9,636
ALOS	10.5	10.2	10.2	10.2
ADC	14.2	16.0	24.0	26.3
Lic. Occ.	88.7%	100%	75.0%	82.3%
Alcohol and Drug Beds	17	17	12	12
Admissions	235	282	324	357
Pat. Days	2,066	2,479	2,851	3,136
ALOS	8.8	8.8	8.8	8.8
ADC	5.7	6.8	7.8	8.6
Lic. Occ.	33.3%	40.0%	65.1%	71.4%

Source: CN1803-018

ECONOMIC FEASIBILITY

Project Cost

The anticipated total project cost is \$91,000. Major costs are:

- Legal, Administrative, and Consultant Fees-\$50,000, or 55% of cost.
- Moveable Equipment- \$21,000, or 23.1% of cost.
- For other details on Project Cost, see the Project Cost in the original application.

Financing

• The applicant submitted a letter dated March 15, 2018 from the Chief Financial Officer of Crestwyn Behavioral Health confirming the availability of cash reserves to fund the \$91,000 proposed project.

Acadia Healthcare Company, Inc. financial statements filed with the U.S. Securities and Exchange Commission for the period ending December 31, 2016 indicates \$57,063,000 in cash, total current assets of \$427,927,000, total current liabilities of \$342,865,000 and a current ratio of 1.25:1.

Note Agency Members: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Net Operating Margin Ratio

• The applicant projects a net operating margin ratio for the total facility of 21.3% in Year 1 and 21.6% in Year 2.

Note to Agency Members: The net operating margin demonstrates how much revenue is left over after all the variable or operating costs have been paid.

Capitalization Ratio

Crestwyn Behavioral Health's capitalization ratio is 57.56%.

Note to Agency Members: The capitalization ratio measures the proportion of debt financing in a business's permanent financing mix.

Historical Data Chart

• According to the Historical Data Chart, Crestwyn Behavioral Health realized a negative Free Cash Flow (Net Balance + Depreciation) balance of (\$27,046,446) in partial Year 2016 and \$270,117 in 2017.

Projected Data Chart

For the total facility including the proposed project, the applicant projects \$39,537,378.00 in total gross revenue on 22,749 days during the first year of operation and \$42,911,187 on 24,022 days in Year Two (approximately \$1,786 per day). The Projected Data Chart reflects the following:

- Free Cash Flow (Net Balance + Depreciation) for the applicant will equal \$1,321,015 in Year One increasing to \$1,549,733 in Year Two.
- Net operating revenue after contractual adjustments is expected to reach \$17,502,380 or approximately 40.7% of total gross revenue in Year Two.
- Charity care at approximately 1.0% of total gross revenue in Year One and Year Two equaling to \$395,134 (227 days) and \$428,860 (240 days), respectively.

Charges

In Year One of the proposed project, the average charges are as follows:

- The proposed average gross charge is \$1738/day in 2019.
- The average deduction is \$1,013/day, producing an average charge of \$725/day.

Medicare/TennCare Payor Mix

• The applicant indicates it has plans to contract with all TennCare MCOs available to its service area population: United HealthCare Community Plan, Blue Care/TennCare Select, and AmeriGroup.

Applicant's Payor Mix, Year 1, Proposed Project Only

Payor Source	Gross Revenue	as a % of Gross
	Year 1	Revenue
		Year 1
Medicare/Medicare	\$932,447	22.5%
Managed Care		
Medicaid/TennCare	\$1,918,769	46.3%
Commercial	\$1,147,946	27.7%
Self Pay	\$33,154	0.8%
Charity Care	\$37,298	0.9%
Other	\$74,596	1.8%
Total	\$4,144,210	100%

Source: CN1803-018

PROVIDE HEALTHCARE THAT MEETS APPROPRIATE QUALITY STANDARDS

Licensure

- Crestwyn Behavioral Health is licensed by the Tennessee Department of Mental Health and Substance Abuse Services.
- In Supplemental #2, the applicant indicated since opening in the spring of 2016 Crestwyn Behavioral Health has not received a facility survey from

- the Department of Mental Health and Substance Abuse Services. However, a survey by TDMHSAS is expected to be performed sometime in the early part of 2018.
- A copy of the latest Department of Mental Health and Substance Abuse licensure surveys for two Tennessee inpatient psychiatric facilities owned by the applicant's parent company Acadia Healthcare is located in Supplemental #2.

Certification

• The applicant is currently certified by Medicare and TennCare.

Accreditation

Crestwyn Behavioral Health is accredited by The Joint Commission. A
copy of the latest Joint Commission Accreditation survey dated June 27,
2016-June 29, 2016 is located in Supplemental #1.

Other Quality Standards

- In the first supplemental response the applicant commits to obtaining and/or maintaining the following:
 - Staffing levels comparable to the staffing chart presented in the CON application
 - Licenses in good standing
 - o TennCare/Medicare certifications
 - o Three years compliance with federal and state regulations
 - o Has not been decertified in last three years
 - o Self-assessment and external peer assessment processes
 - o Data reporting, quality improvement, and outcome/process monitoring systems

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

Agreements

• The applicant has a transfer agreement with Baptist Hospital and St. Francis Hospital both located in Shelby County.

Impact on Existing Providers

• The applicant does not anticipate the addition of 24 inpatient psychiatric beds will have a significant impact on other inpatient behavioral health providers in Shelby County.

 Crestwyn Behavioral Health indicates any impact the project may have on other providers is likely to be more than offset by short-term growth in community demand.

Staffing

The applicant's proposed Year 1 direct patient care staffing includes the following:

Position	Existing FTEs	Projected
		FTEs
Mental Health Tech (MHT)	37.80	42.00
Registered Nurse	13.70	16.23
Master's Level Clinician	5.24	6.64
Total Direct Care	56.74	64.87

Source: CN1803-018, Page 62R

The applicant has submitted the required information on corporate documentation and title and deeds. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency's office.

Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for this applicant.

Acadia Healthcare has financial interests in this project and the following:

Letters of Intent

Cumberland Behavioral Health, LLC, CN1806-022, has filed a letter of intent to establish a 76 bed mental health hospital (40 adult psych. and 36 geriatric psych) at 300 Great Circle Road Nashville (Davidson County). If approved, Saint Thomas West will close its 26 bed psychiatric unit. The LLC is a joint venture between St. Thomas Health (50.1%) and Acadia (49.9%). The estimated project cost is \$32,216,800.

Outstanding Certificates of Need

TrustPoint Hospital, CN1606-024A, has an outstanding Certificate of Need that will expire on December 1, 2019. The project was approved at the October 26, 2016 Agency meeting for the net increase of 88 inpatient beds from 129 to 217 as follows: Adult Psychiatric Beds for ages 18-64 increases from 59 to 111 beds; and Geriatric Psychiatric Beds will remain at 36 beds; Medical Detoxification Beds will remain at 18 beds; Physical Rehabilitation Beds increases from 16 beds to 24 beds; Child Psychiatric beds increases from no beds to 14 beds; and Adolescent Beds will also increase from no beds to 14 beds. In addition to the requested 88 additional psychiatric beds, there will be (32) residential beds (not subject to CON review, but built to hospital standards) that will be located in the newly constructed building, 16 beds for adolescents and 16 for children. The estimated project cost was \$57,320,105. Project Status: A representative of the applicant provided a project update on May 18, 2018 which stated construction is running on schedule and on budget for completion before the December 1, 2019 expiration date.

TrustPoint Hospital, CN1502-006A, has an outstanding Certificate of Need that will expire on July 1, 2019. The project was approved at the May 25, 2015 Agency meeting for the net increase of 33 inpatient beds as follows: Adult Psychiatric Beds will increase from 31 beds to 59; Geriatric Psychiatric will increase from 28 beds to 36; Medical Detoxification beds will increase from 10 to 18 beds, Physical Rehabilitation Beds will decrease from 27 beds to 16 beds; with total beds increasing from 96 to 129 beds. The estimated project cost was \$935,000.00. Project Status: A representative of the applicant provided a project update on May 18, 2018 which stated construction is running on schedule and on budget for completion before the July 2019 expiration date.

Erlanger Behavioral Health, LLC, CN1603-012A, has an outstanding Certificate of Need that will expire on October 1, 2019. The project was approved at the August 24, 2016 Agency meeting for the construction of a new 88 inpatient licensed bed psychiatric hospital located at the intersection of North Holtzclaw Avenue and Citico Avenue, Chattanooga (Hamilton County), TN. The psychiatric hospital will consist of the following inpatient units: adult (24 beds); geriatric (24 beds); children and adolescent (18 beds); and adult chemical dependency services (22 beds). The estimated project cost was \$25,112,600. Project Status: A General Counsel Report at the February 28, 2018 Agency meeting indicated construction was underway with the Certificate of Occupancy expected to be issued in May 2018.

Tenet Healthcare has an interest in this project and the following:

Denied Applications

Saint Francis Hospital-Bartlett, CN1704-004D, was denied at the April 26, 2017 Agency meeting for the establishment of a satellite emergency department (ED) containing 12 treatment rooms in a 1-story 15,240 square foot building to be constructed on a 3.5 acre site near intersection of the Southeast Corner of I-40 and Airline Road, Arlington (Shelby County), a distance of approximately 9.0 miles northeast of SFH-Bartlett's 33-room ED on the main hospital campus in Memphis. The estimated project cost was \$12,857,628. Reason for Denial: The application did not meet statutory criteria.

Outstanding Certificates of Need

Bartlett ASC, LLC, CN1605-020A, has an outstanding Certificate of Need that will expire on December 1, 2018. The project was approved at the October 26, 2016 Agency meeting for the establishment of a multi-specialty ambulatory surgical center (ASTC) providing outpatient surgery services. The estimated project cost was \$9,837,855.48. Project Status: The applicant filed a CON application in June 2018 to relocate this project.

Baptist Health Systems has an interest in this project and the following:

Denied Applications

Baptist Memorial Hospital, CN1705-018D, was denied at the August 23, 2017 Agency meeting for the establishment of a satellite emergency department (ED) containing 8 treatment rooms in a 1-story 13,750 square foot building to be constructed on a 1.65 acre site near the intersection of I-40 and Airline Road, in Arlington (Shelby County), a distance of approximately 16.7 miles northeast of BMH's 54-room ED on the main hospital campus in Memphis. The applicant's proposed satellite ED was to serve a 13 ZIP code service area and be operated under BMH's license but be developed, operationalized, and marketed through a joint operation agreement between BMH and Regional One Health. The estimated project cost was \$10,016,611. Reason for Denial: The application did not meet statutory criteria.

Baptist Memorial Hospital, CN1701-005D, was denied at the April 26, 2017 Agency meeting for the establishment of a full service, 24 hour per day/7 day per week satellite emergency department to be located at an unnamed street

address north of the intersection of Interstate 40 and Airline Road on the eastside, in Arlington (Shelby County). The proposed facility was planned to operate as a satellite emergency department of Baptist Memorial Hospital located at 6019 Walnut Grove Road in Memphis (Shelby County) and have 10 treatment rooms and provide emergency diagnostic and treatment services. The applicant is owned by Baptist Memorial Health Care Corporation. The project was planned to be developed, operationalized, and marketed through a joint operating agreement between Baptist Memorial Hospital and Regional One Health. The estimated project cost was \$9,963,779. Reason for Denial: The application failed to meet the statutory criteria.

Baptist Memorial Hospital Satellite ED Lakeland, CN1508-037D, was denied at the November 18, 2015 Agency meeting. The application was for the establishment of a full service, 24 hour per day/7 day per week satellite emergency department to be located at an unnamed street address near the intersection of Highway 64 and Canada Road in Lakeland (Shelby County), Tennessee 38002. The proposed facility was planned to be operated as a satellite emergency department of Baptist Memorial Hospital located at 6019 Walnut Grove Road in Memphis and was to have 10 treatment rooms and provide emergency diagnostic and treatment services. The project did not contain major medical equipment, initiate or discontinue any other health service or affect the hospital's licensed bed complement. The estimated project cost was \$18,718,029. Reason for Denial: The application failed to meet the statutory criteria.

Baptist Memorial Hospital Satellite ED Memphis, CN1508-036D, was denied at the November 18, 2015 Agency meeting. The application was for the establishment of a full service, 24 hour per day/7 day per week satellite emergency department to be located at an unnamed street address at 655 Quince Road in Memphis (Shelby County), Tennessee 38119. The proposed facility was to be operated as a satellite emergency department of Baptist Memorial Hospital located at 6019 Walnut Grove Road in Memphis and have 12 treatment rooms and provide emergency diagnostic and treatment services. The project did not contain major medical equipment, initiate or discontinue any other health service or affect the hospital's licensed bed complement. The estimated project cost was \$18,457,700. Reason for Denial: The application failed to meet the need or orderly development of health care.

Outstanding Certificates of Need

Baptist Memorial Hospital, CN1512-066A, has a Certificate of Need that will expire on April 1, 2019. The project was approved at the February 2016 Agency

meeting for the renovation and equipment upgrade of 5 cardiovascular catheterization labs located on the concourse floor of the main hospital building. The proposed project totaled 14,556 SF of total renovation, which included renovation of 7,278 total square feet of catheterization suite area, and 9,175 SF of mechanical/electrical and circulation areas. The estimated project cost was \$6,109,654. Project Status Update: A representative of the applicant provided a project update on March 9, 2018 stated the project had received state inspection approval. The final project report is pending.

<u>CERTIFICATE OF NEED INFORMATION FOR OTHER FACILITIES IN THE</u> SERVICE AREA:

There are no other Letters of Intent or pending applications for other health care organizations in the service area proposing this type of service.

Denied Applications

Keystone Memphis LLC d/b/a Compass Intervention Center, CN1606-025D, was denied at the December 14, 2016 Agency meeting for the establishment of a new 48 bed mental health hospital and initiation of psychiatric services for children and adolescents up to age 18. The proposed mental health hospital was to have consisted of 48 inpatient beds for psychiatric care: 24 inpatient beds for children up to age 13 and 24 inpatient beds for adolescents ages 13-17. The estimated project cost was \$12,152,661.00. Reason for Denial: the application did not meet statutory criteria.

Outstanding Certificates of Need

Methodist Healthcare-Memphis Hospitals d/b/a Methodist North Hospital, CN1709-029A, has a Certificate of Need that will expire on February 1, 2021. The application was approved at the December 13, 2017 Agency meeting for the relocation of a 34 licensed bed adult psychiatric inpatient unit currently located at the Methodist University Hospital campus at 1265 Union Avenue in Memphis (Shelby County), TN 38104 to the Methodist North Hospital campus located at 3960 New Covington Pike, Memphis (Shelby County), TN 38128. The service area consists of Shelby County. The applicant is owned by the Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System. The estimated project cost was \$2,295,000. A representative of the applicant provided a project update on May 21, 2018 which stated the project design was complete with bids being requested for construction to start in July 2018. Project is slated to be completed by summer of 2019.

Woodridge of West Tennessee, LLC CN1703-011A, has a Certificate of Need that will expire on October 1, 2020. The application was approved at the August 23, 2017 Agency meeting for the addition of 16 geriatric psychiatric beds to its existing mental health hospital, Oak Hills Behavioral Center. The licensed geriatric beds increased from 16 to 32 beds. The estimated project cost was \$787,190. Project Status Update: A May 21, 2018 update from a representative of the project indicates construction is complete with preparations underway to open the additional psych beds.

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, HEALTH CARE THAT MEETS APPROPRIATE QUALITY STANDARDS, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME 6/18/2018

LETTER OF INTENT

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Commercial Appeal, which is a newspaper of general circulation in Shelby County, Tennessee, on or before March 10, 2018, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Crestwyn Behavioral Health (a behavioral health hospital), owned and managed by Crestwyn Health Group, LLC (a limited liability company), intends to file an application for a Certificate of Need to add fourteen (14) licensed beds to its facility at 9485 Crestwyn Hills Cove, Memphis, TN 38125, at a capital cost estimated at \$100,000.

The facility is licensed for 66 Mental Health Hospital beds by the Department of Mental Health and Substance Abuse Services. These consist of 33 adult psychiatric beds, 16 child/adolescent psychiatric beds, and 17 adult dual diagnosis/substance abuse beds.

This project proposes to increase total licensed beds to 80 beds. The adult units will be increased to 36 beds (increase of 3). The child/adolescent units will be increased to 32 beds (increase of 16). The dual diagnosis/substance abuse beds will be reduced from 17 beds to 12 beds (decrease of 5). All bed increases will be in existing semi-private size patient rooms that are currently used as single rooms. The project requires no construction. The project does not contain major medical equipment or initiate or discontinue any health service.

The anticipated date of filing the application is on or before March 15, 2018. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

Jelle Swellbon 3/8/18 jwdsg@comcast.net (Signature) (Date) (E-mail Address)

Application Copy

Crestwyn Behavioral Health Memphis (Shelby Co.)

CN1803-018

CERTIFICATE OF NEED APPLICATION CRESTWYN BEHAVIORAL HEALTH GERMANTOWN, SHELBY COUNTY

FOR THE ADDITION OF 14 PSYCHIATRIC BEDS

Filed March 2018

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

Crestwyn Behavioral Health		
Name		
9485 Crestwyn Hills Cove		Shelby
Street or Route		County
Memphis	TN	38125
City	State	Zip Code
www.crestwynbh.com		
Website Address		

2. Contact Person Available for Responses to Questions

John Wellborn	Consultant			
Name	Title			
Development Support Group	jwdsg@comcast.net			
Company Name	E-Mail Address			
4219 Hillsboro Road, Suite 210	Nashville	TN	37215	
Street or Route	City	State	Zip Code	
CON Consultant	615-665-2022		615-665-2042	
Association With Owner	Phone Number		Fax Number	

NOTE: Section A is intended to give the applicant an opportunity to describe the project. Section B addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures. Please answer all questions on 8.5" X 11" white paper, clearly typed and spaced, single-sided, in order and sequentially numbered. In answering, please type the question and the response. All questions must be answered. If an item does not apply, please indicate "N/A" (not applicable). Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed and signed notarized affidavit.

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview <u>not to exceed three pages in total</u>, explaining each numbered point.

(1) Description (Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant.)

Crestwyn Behavioral Health ("CBH") is a 66-bed acute care mental health in the Germantown area of southeast Shelby County. It offers adult and geriatric adult psychiatric care; adolescent psychiatric care; and dual diagnosis (psychiatric and substance abuse) care.

The hospital is a joint venture among two Memphis acute care providers--Baptist Hospital and St. Francis Hospital--and Crestwyn Health Group, LLC. The latter is a subsidiary of Acadia Healthcare, a national behavioral healthcare company headquartered in Tennessee. Acadia partners with not-for-profit hospital systems across the country and across Tennessee.

Responding to this collaborative effort, the HSDA granted Crestwyn CN1310-040 for 60 beds in January 2014; and the hospital opened in 2016. Its CON application had projected attaining 45% occupancy in its first full calendar year of operation. However, the service area's needs filled Crestwyn to 73.5% occupancy in its first full calendar year of operation (2017). Crestwyn projects exceeding 80% average occupancy for this current calendar year.

In July, the Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) increased Crestwyn's license from 60 to 66 beds, under the exemption allowance in the CON statute. The 6 additional beds have been put into service in existing patient rooms, and the 66-bed complement has been more than 83% occupied in the early weeks of this year.

Crestwyn's 40 patient rooms were all built for semiprivate occupancy. Under its 66-bed license, 26 of those rooms are now equipped as semi-privates (52 beds) and 14 are equipped as private rooms (14 beds).

This project will place 14 more beds in Crestwyn's remaining semi-private size rooms without any new construction. The addition will result in 80 licensed beds in 40 semi-private rooms--the maximum complement Crestwyn can license without constructing an additional wing of beds. As needed, semi-private rooms can be restricted to private occupancy to provide for appropriate separation or isolation.

Table A-3A(1a): Crestwyn Behavioral Health Proposed Changes in Licensed Beds						
	CY 2016 Beds	CY2018 Beds	Proposed Beds	Change in Beds		
Adult	30	33	36	+3		
Adolescent	15	16	32	+16		
Dual Diagnosis	15	17	12	-5		
Total	60	66*	80	+14		

^{* 6} bed license increase granted by TDMHSAS under exemption clause in CON statute.

Cha	Table A-3A(1b): Crestwyn Behavioral Health Changes in Bed Capacity, Licensed Beds, and Type of Room						
Phase	Rooms	Room Size	Bed Capacity	Beds Licensed	Change	Semi- private Use	Private Use
At Opening 2016	40	SP	80	60		20 rooms 40 beds	20 rooms 20 beds
Currently 2018	40	SP	80	66	+6	26 rooms 52 beds	14 rooms 14 beds
Proposed 2019	40	SP	80	80	+14*	40 rooms 80 beds	As Needed

^{*} Currently there are 14 semiprivate size rooms being used as private rooms (one patient only) due to CON restrictions.

(2) Ownership Structure

The applicant and license holder is "Crestwyn Health Group, LLC DBA Crestwyn Behavioral Health". It is jointly owned by three entities listed in the table below. Acadia Crestwyn Holdings, LLC, the majority member of the CON applicant and licensee, is a wholly owned subsidiary of Acadia Healthcare. Acadia Amisub (SFH), Inc. is the local subsidiary of Saint Francis Hospital's national parent, Tenet. Baptist Memorial Health Services, Inc, is an entity of the Baptist Hospital System of Shelby County. The facility is member-managed by the LLC's majority member Acadia Healthcare; no formal management contract is being utilized.

Table A-3A(2): Ownership of the Applicant Crestwyn Health Group, LLC DBA Crestwyn Behavioral Health				
Name of Owning Entity	Percentage of Membership Interests			
Acadia Crestwyn Holdings, LLC	60%			
Amisub (SFH), Inc.	20%			
Baptist Memorial Health Services, Inc.	20%			

3) Service area

• Crestwyn's admissions last year came from 103 counties in Tennessee and other States. They came from 60 Tennessee counties. However, approximately 60% are from Shelby County, and only one other county contributed 3%. Fifty-three counties contributed 1% or less.

Therefore Shelby County is being declared as the applicant's primary service area ("PSA") with 25 other Tennessee, Mississippi, and Arkansas counties being included as secondary service area ("SSA") counties. Knox, Davidson, and Rutherford Counties contribute 9-11 annual admissions as well, more than some of the listed counties, but each constitutes less than 1% of admissions and is too far away to be identified in a a largely contiguous secondary service area.

Ta	ble A-3A(3): Service Area (W	est TN and MS/AR)
	Primary Service AreaSh	nelby County
Secondary S	ervice Area Counties in Tennes	see, Arkansas, Mississippi (25)
Benton	Fayette	Lauderdale
Benton MS	Gibson	Lawrence AR
Carroll	Hardeman	Madison
Chester	Hardin	Marshall MS
Crittenden AR	Haywood	McNairy
Crockett	Henderson	Obion
Decatur	Henry	Tipton
Desoto MS	Fayette	
Dyer	Lake	

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• Based on last year's patient origin at Crestwyn there will also be referrals from counties and States beyond these areas, comprising approximately 13% of admissions.

(4) Existing similar service providers

- In the primary service area (PSA) there are 14 licensed providers offering acute inpatient behavioral care. They consist of dedicated behavioral health hospitals and behavioral health units of general hospitals. Of those providers, 7 are in Shelby County; 6 are in other West Tennessee counties; and 1 is in nearby Mississippi.
- The providers include State mental health hospitals in West Tennessee, privately owned hospitals, and distinct-part behavioral units of general hospitals. A full list of all the area's providers, bed complements, and addresses is provided in Section B.Need.3 of the application.

(5) Project cost

• The project cost consists of the CON process cost and furniture for existing patient rooms. This minimal project cost estimated at \$91,000.

(6) Funding

• Crestwyn Behavioral Health, the applicant, will fund the small capital costs of the project.

(7) Financial feasibility, including when the proposal will realize a positive financial margin; and

- This is an existing hospital that operates with a positive margin. The project cost is minimal. The project when implemented will not reduce the hospital's already positive operating margin.
- The hospital has available funds to implement the project.

(8) Staffing

• The project will require the addition of 8.80 FTEs of employed and contract staff, including 8.13 clinical FTE's consisting of 4.2 mental health techs, 2.53 RN's, and 1.4 Master's Level Clinicians.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B of this application. Please summarize, in one page or less, each of the criteria.

(1) Need

Crestwyn Behavioral Health is a highly regarded 66-bed mental health hospital in Shelby County. It is an innovative joint venture among three hospital systems: Baptist Hospital, St. Francis Hospital, and Acadia Healthcare (which is a behavioral healthcare company headquartered in Tennessee, with facilities worldwide.) The project for which it seeks HSDA approval is the licensure of 14 more psychiatric beds in existing hospital rooms, at a minimal capital cost involving only furnishings, not construction.

The project responds to an area need for more inpatient treatment capacity at Crestwyn, identified by numerous local mental health agencies working in this service area--such as the National Alliance on Mental Illness (NAMI), Youth Villages and Alliance Healthcare Services (TennCare's two designated crisis intervention teams for West Tennessee), Serenity Recovery Center, Professional Care Services of West Tennessee, and other significant organizations and elected officials.

Crestwyn has a large primary and secondary service area of 31 counties with 1,152 psychiatric beds, including beds at two State mental health hospitals. This small project would increase the area's licensed beds by only 14 beds. But those beds will relieve a daily shortage of capacity at a facility whose adult and child/adolescent psychiatric beds now operate at more than 90% occupancy. The bed increase and an internal reassignment of other beds will allow Crestwyn to double its complement of child and adolescent beds and to continue to work closely with community agencies who depend on its bed availability.

This will allow the dual diagnosis beds to operate at high efficiency (almost 87% in Year Four, CY2022). It will provide room for program growth in adult and adolescent programs, which are currently full and are turning away admissions requests for lack of bed availability. With demand trends continuing, Crestwyn anticipates reaching overall 82% occupancy in Year Two of this project (2020) and 90% occupancy in Year Five (2023).

Crestwyn is a good partner to its community. It operates with a 48% TennCare, self-pay, and charity payor mix. It was opened in 2016 without the licensure of any additional beds to the service area, thanks to beds contributed to it by three hospital systems. This time, Crestwyn is requesting a very small 1.2% increase in service area bed complements, in order to completely fill its designed capacity. The project is based on this provider's needs; but the provider plays an important role in Shelby County and the rest of West Tennessee. Its modest increase in capacity will help the communities it serves, and the agencies who are supporting the project.

In addition, the service area's patient days for behavioral care increased more than 15,000 days in the past two JAR reporting years. The 14 beds requested by Crestview, at 100% occupancy, could not provide more than 5,110 patient days of care. It appears that normal growth in area demand for this type of care will more than offset the impact that the additional 14 beds could have on other providers.

(2) Economic Feasibility

Crestwyn Behavioral Health currently operates with a positive cash flow and positive operating margin. The proposed bed additions will be accomplished at a very low capital cost, without new debt service, and the beds will allow for increased admissions and increased revenues. The Projected Data Charts in the application demonstrate the economic feasibility of the facility both currently, and with the project operational.

The very minor capital funding required for Phase One of this project will be provided by the hospital, whose financial statements document the availability of sufficient funds.

(3) Appropriate Quality Standards

The hospital is currently licensed by the Tennessee Department of Mental Health and Substance Abuse Services, and is fully accredited by the Joint Commission. It meets all relevant quality standards of those organizations--and of Acadia Healthcare, which has strong quality improvement programs in its hospital facilities.

(4) Orderly Development of adequate and effective health care

Crestwyn's approval in CY2014 reflected a CON Board consensus that there was a need to better distribute inpatient acute psychiatric beds into southeast Shelby County. The application projected that this would be met by a region-wide demand for, and high utilization of, beds at that location.

The projection was validated by the referrals that Crestwyn experienced in its first year of operation, from virtually all of West Tennessee and from adjoining States. This reflects the effectiveness of its care in the eyes of the region and referring caregivers. Crestwyn's adult and child and adolescent beds are full. This proposed 14-bed filling-out of existing patient bed spaces, with a reassignment of some of the dual diagnosis beds to child and adolescent care, will add to the facility's effectiveness in meeting regional needs.

This phased expansion can be accomplished in an orderly way, and at a very economical cost, because the hospital was prudently designed to allow for future conversions of single-occupancy patient rooms to semiprivate rooms as needed, without additional construction. This increase in licensed bed capacity will not necessitate construction of new bed capacity.

Crestwyn Behavioral Health opened less than two years ago. Its innovative ownership model was a first for the State of Tennessee. Two large local non-profit and for-profit hospital systems joined a national behavioral care system, to demonstrate the effectiveness of joint efforts and deep expertise in managing inpatient behavioral health needs of adolescents and adults. This joint ownership approach has inspired superior consumer confidence in the region, filling Crestwyn's beds to overflow in a matter of months. This application requests approval of an orderly, phased expansion of a facility that many referral sources in the region regard as a destination of choice.

C. Consent Calendar Justification

If consent calendar is requested, please provide the rationale for an expedited review. A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Not applicable.

SECTION A (CONTINUED): PROJECT DETAILS

4.A. Owner of the Facility, Agency, or Institution

Crestwyn Health Group, LLC DBA Crestwyn Behavioral Health		901-248-1495		
Name		Phone Number		
c/o Acadia Healthcare, 6100 Tower Circle, Suite	1000	Davidson		
Street or Route		County		
Franklin	TN	37067		
City	State	Zip Code		

B. Type of Ownership or Control (Check One)

	F. Government (State of TN or	
A. Sole Proprietorship	Political Subdivision)	
B. Partnership	G. Joint Venture	
C. Limited Partnership	nip H. Limited Liability Company	
D. Corporation (For-Profit)	I. Other (Specify):	
E. Corporation (Not-for-Profit)		

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the TN Secretary of State's website hpps://tnbear.tn.gov/Ecommerce/FilingSearch.aspx.

See Attachment Section A-4A.

<u>Describe</u> the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.

Supplemental #1

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An organization chart is included in Attachment Section A-4A. The applicant is a joint ventured, limited liability company. It is 60% owned by Acadia Healthcare, Inc. (a publicly traded national behavioral healthcare company), and by two Shelby County hospital providers, Baptist Memorial Hospital, Inc. (20%) and Amisub (SFH), Inc. (20%). The latter is a legal entity representing St. Francis Hospital, wholly owned by Tenet Healthcare, a multinational healthcare system headquartered in Dallas, Texas.

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5A. Name of Management/Operating Entity (If Applicable) NA

The LLC is member-managed.

	18 318
	County
State	Zip Code
	State

Website Address

For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.

Not applicable.

6A. Legal Interest in the Site of the Institution (Check One)

A. Ownership	x	D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of Years			

Check appropriate line above: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements must include anticipated purchase price. Lease/Option to Lease Agreements must include the actual/anticipated term of the agreement and actual/anticipated lease expense. The legal interests described herein must be valid on the date of the Agency's consideration of the certificate of need application.

See Attachment Section A-6A for a copy of the deed.

- 6B. Attach a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site, on an 8.5" X 11 sheet of white paper, single-sided. Do not submit blueprints. Simple line drawings should be submitted and need not be drawn to scale.
- (1) Plot Plan must include:
 - a. Size of site (in acres);
 - b. Location of structure on the site;
 - c. Location of the proposed construction/renovation; and
 - d. Names of streets, roads, or highways that cross or border the site.

See Attachment A-6B-1 for the facility's plot plan.

(2) Attach a floor plan drawing for the facility, which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8.5" X 11" sheet of paper or as many as necessary to illustrate the floor plan.

See Attachment A-6B-2 for floor plans depicting existing and proposed patient beds,

(3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

The table on the following page provides drive times and distances from the Crestwyn site to the principal communities in the primary and secondaryservice area counties.

The service area map in this application shows that the primary service area counties have access to Crestwyn via good highways. Via Winchester Road, Crestwyn's site is approximately 15 minutes' drive from I-240, the interstate loop around Memphis, crossed by numerous Interstate and U.S. highways radiating out in all directions: U.S. 51, U.S. 79, I-40, and U.S. 64 northwest and west across West Tennessee; U.S. 72 and U.S. 78 southeast across Mississippi; U.S. 61 and I-55 south across Mississippi; U.S. 64, I-40 and U.S. 79 West and southwest across Arkansas; and U.S 61, U.S. 63, and I-55 north into Arkansas.

Crestwyn also has access to I-40 Exit 16, via Highway 177 North and Poplar Avenue / Winchester Road. That route allows patients driving in on I-40 from rural West Tennessee to leave I-40 and head due south into Germantown, before reaching heavy traffic on the I-240 loop around Memphis.

The Memphis Area Transit Authority's closest municipal bus service stop is Winchester and Hacks Cross, approximately 2.8 miles from the campus.

Table A-6B(3): Mileage and Drive Times Between the Project and Major Communities in the Primary Service Area				
Counties	Community	Distance in Miles	Drive Time	
West Tennessee			21170 IIIIC	
Benton	Camden	143	132 min.	
Carroll	Huntingdon	117	112 min.	
Chester	Henderson	83	95 min.	
Crockett	Alamo	79	84 min.	
Decatur	Decaturville	114	130 min.	
Dyer	Dyersburg	91	102 min.	
Fayette	Somerville	40	43 min.	
Gibson	Humboldt	93	89 min.	
Hardeman	Bolivar	58	65 min.	
Hardin	Savannah	102	113 min.	
Haywood	Brownsville	62	60 min.	
Henderson	Lexington	109	102 min.	
Henry	Paris	143	141 min.	
Lake	Tiptonville	117	134 min.	
Lauderdale	Ripley	69	80 min.	
Madison	Jackson	87	83 min.	
McNairy	Selmer	80	87 min.	
Obion	Union City	132	135 min.	
Shelby	Memphis (Center)	25	27 min.	
Tipton	Covington	51	65 min.	
Weakley	Martin	133	136 min.	
Mississippi				
Benton MS	Ashland	43	47 min.	
DeSoto MS	Horn Lake	29	33 min.	
Marshall MS	Holly Springs	31	39 min.	
Arkansas			O Mini.	
Crittenden AR	Marion	36	39 min.	
Lawrence AR	Walnut Ridge	116	110 min.	

Source: Google Maps, July 2017

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7. Type of Institution (Check as appropriate—more than 1 may apply)

A. Hospital (Specify):		H. Nursing Home	
B. Ambulatory Surgical Treatment		I. Outpatient Diagnostic Center	
Center (ASTC) Multi-Specialty			
C. ASTC, Single Specialty		J. Rehabilitation Facility	
D. Home Health Agency		K. Residential Hospice	
E. Hospice		L. Non-Residential Substitution-	
•		Based Treatment Center for	
		Opiate Addiction	
F. Mental Health Hospital	X	M. Other (Specify):	
G. Intellectual Disability			
Institutional Habilitation Facility			
ICFF/IID			

8. Purpose of Review (Check as appropriate-more than 1 may apply)

A. New Institution	F. Change in Bed Complement Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation	X
B. Modifying an ASTC with limitation still required per CON C. Addition of MRI Unit D. Pediatric MRI	G. Satellite Emergency Department H. Change of Location I. Other (Specify):	
E. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)		

9. Medicaid/TennCare, Medicare Participation

MCO Contracts (Check all that apply:
x Amerigroup x United Healthcare Community Plan x BlueCare
x TennCare Select
Medicare Provider Number: 44-4025
Medicaid Provider Number: Q023745
Certification Type: Mental Health Hospital
If a new facility, will certification be sought for Medicare or for Medicaid/TennCare?
Medicare Yes No N/A x
Medicaid/TennCare Yes No N/A x

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10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.)

	Beds Currently Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempt	TOTAL Beds at Completion
1. Medical					7.0	
2. Surgical						
3. ICU/CCU						
4. Obstetrical						
5. NICU						
6. Pediatric						
7. Adult & Geriatric						
Psychiatric	33	33	+3			36
8. Geriatric Psychiatric						
9. Child/Adolescent						
Psychiatric	16	16	+16			32
10. Rehabilitation						
11. Adult Chemical						
Dependency	17	17	-5			12
12. Child/Adolescent						
Chemical Dependency						
13. Long-Term Care						
Hospital						
14. Swing Beds						
15. Nursing Home SNF						
(Medicare Only)						
16. Nursing Home NF						
(Medicaid Only)						
17. Nursing Home						
SNF/NF (dually						
certified MCare/Maid)						
18. Nursing Home-		1				
Licensed (Noncertified)						
19. ICF/IID						
20. Residential Hospice						
TOTAL	66	66	+14	0	0	80

^{*} Beds approved but not yet in service

^{**} Beds exempted under 10% / 3 yrs provision

B. Describe the reasons for change in bed allocations and describe the impact the bed changes will have on the applicant facility's existing services.

Adding 14 additional beds will allow Crestview Behavioral Health to expand its level of service to the community, in its current inpatient psychiatric programs for geriatric and non-geriatric adults and for child and adolescent programs. It will provide a platform for moving from purely adolescent care into a children's program after two years.

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete the chart below.

Acadia Healthcare Company, Inc., the majority owner of the applicant LLC, has two outstanding Tennessee Certificates of Need, as follows.

CON Number	CON Expiration Date	Total Licensed Beds Approved
CN1606-024	December 1, 2019	88 beds to be added
CN1603-012	October 1, 2019	88 bed new facility

11. <u>Home Health Care Organizations – Home Health Agency, Hospice Agency</u> (excluding Residential Hospice), identify the following by checking all that apply:

Not applicable.

12. COST PSF TABLE

Not applicable; the project has no construction cost.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper, single-sided. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Provide a response to each criterion and standard in Certificate of Need categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the THSDA or found on the agency's website at http://tjn.gov/hsda/article/hsda-criteria-and-standards.

STATE HEALTH PLAN CERTIFICATE OF NEED STANDARDS AND CRITERIA FOR PSYCHIATRIC INPATIENT SERVICES

Standards and Criteria

1. Determination of Need: The population-based estimate of the total need for psychiatric inpatient services is a guideline of 30 beds per 100,000 general population, using population estimates prepared by the TDH and applying the applicable data in the Joint Annual Report (JAR). These estimates represent gross bed need and shall be adjusted by subtracting the existing applicable staffed beds including certified beds in outstanding CONs operating in the area as counted by the TDH in the JAR. For adult programs, the age group of 18-64 years shall be used in calculating the estimated total number of beds needed; additionally, if an applicant proposes a geriatric psychiatric unit, the age range 65+ shall be used. For child inpatients, the age group is 12 and under, and if the

program is for adolescents, the age group of 13-17 shall be used. The HSDA may take into consideration data provided by the applicant justifying the need for additional beds that would exceed the guideline of 30 beds per 100,000 general population. Special consideration may be given to applicants seeking to serve child, adolescent, and geriatric inpatients. Applicants may demonstrate limited access to services for these specific age groups that supports exceeding the guideline of 30 beds per 100,000 general population. An applicant seeking to exceed this guideline shall utilize TDH and TDMHSAS data to justify this projected need and support the request by addressing the factors listed under the criteria "Additional Factors".

Rationale: Many communities in Tennessee have unique needs for inpatient psychiatric beds. The above formula functions as a "base criteria" that allows applicants to provide evidence supporting a need for a higher number of beds in the proposed service area. The HSDA may take into account all evidence provided and approve applications that request beds that exceed the 30 beds per 100,000 guideline when needed. An analysis of admissions and discharges by age category performed by the HSDA suggests there may be limited access for inpatients under the age of 18 and inpatients aged 65 and over. However, the applicable JAR form does not provide occupancy rates by age category. Health Planning believes developing determination of need formulas specific to each age category is not possible at this time due to these limitations in available data. The current need formula is to be utilized as a guideline allowing applicants the opportunity to apply to serve the unique needs of the intended service area.

Response:

The State Health Plan uses a planning standard of 30 beds per 100,000 population, making no distinctions between use rates by age. The 30-bed standard is to be applied to children, adolescents, and all adults. While the HSDA default planning horizon is four years from the present year, a later section of the State Plan criteria asks for a two-year projection. The applicant is providing both.

On the next page, tables identify net bed needs and surpluses using the most recent JAR information and licensing records. Approval of this project will increase total licensed beds in the project service area by only 1.2%. It will increase Shelby County beds by only 1.8%.

On the second following page, the applicant has applied the State methodology to project bed need for the three age cohorts, and for both the primary and secondary service areas.

Crestwyn and some other behavioral health facilities have very large multi-State service areas. Crestwyn's extends far beyond West Tennessee and nearby Mississippi and Arkansas counties. It is problematic to make CON findings relying exclusively on bed surplus calculations for just its immediate service area, when Crestwyn receives admissions from 103 U.S. counties.

Table Need-State Health Plan-Standard 1A: Service Area A	
Using State Health Plan Standard of 30 Beds Per 10	0,000 Population
PROJECTION FOR CY2020	
Combined Primary and Secondary Service Area Counties	
2020 Population	2,931,773
Behavioral Bed Need @ 30 Per 100,000 Population	879
Licensed Beds, 2018 (TN & MS)	1,152
Bed Need (Surplus) on Licensed Beds	(273)
Staffed Beds (TN and MS)	969
Bed Need (Surplus) on Staffed Beds (TN only)	(90)
PROJECTION FOR CY2022	
Combined Primary and Secondary Service Area Counties	
2022 Population	2,961,410
Behavioral Bed Need @ 30 Per 100,000 Population	888
Licensed Beds, 2018 (TN & MS)	1,152
Bed Need (Surplus) on Licensed Beds	(264)
Staffed Beds (TN and MS)	969
Bed Need (Surplus) on Staffed Beds (TN only)	(81)

Source: Population data from Table Need-State Health Plan-Standard 1B on following page. Bed numbers are from Joint Annual Reports and Mississippi State Plan.

Notes on Bed Counts

- 1. PSA licensed beds in 2016 (744) plus 2017 additions of 6 beds at Crestwyn and 16 and Behavioral Health Center at Memphis = 766 licensed beds for Shelby County currently.
- 2. PSA staffed beds in 2016 (610) plus addition of presumably staffed 6 beds at Crestwyn and 16 at Behavioral Health currently = 632 staffed beds for Shelby County currently.
- 3. SSA licensed beds (386) are not known by the applicant to have changed since 2016.
- 4. SSA staffed beds (337) are not known by the applicant to have changed since 2016.

State		2018	œ			2020	0			2022	2	
Countly	0-17	18-64	€ 2•	Total	0-17	18-64	+99	Total	0-17	18-64	+499	Total
PSA County												
Shelby	249,747	595,076	125,389	970,212	252,312	593,476	135,234	981,022	254,626	590,155	144,987	989,768
SSA Counties (25)												
Benton	3,045	9,335	4,331	16,711	2,977	9,196	4,568	16,741	2,915	866′8	4,824	16,737
Carroll	6,105	16,308	6,340	28,753	950'9	16,057	699'9	28,782	6,077	15,832	686'9	28,858
Chester	3,913	11,326	3,394	18,633	3,880	11,508	3,590	18,978	3,908	11,544	3,844	19,256
Crockett	3,570	8,480	2,932	14,982	3,554	8,447	3,079	15,080	3,575	8,353	3,239	15,167
Decatur	2,410	6,527	3,092	12,029	2,372	6,442	3,263	12,077	2,369	6,404	3,484	12,257
Dyer	9,316	23,052	7,239	39,607	608'6	22,926	7,637	39,872	9,324	22,725	8,076	40,125
Fayette	658'6	26,864	6,885	46,608	10,014	27,325	11,171	48,510	10,058	27,528	12,542	50,128
Gibson	12,372	29,768	9,794	51,934	12,397	29,786	10,255	52,438	12,246	29,693	10,673	52,612
Hardeman	5,270	17,125	4,889	27,284	5,143	16,964	5,171	27,278	5,023	16,841	968'S	27,260
Hardin	5,290	15,053	6,337	26,680	5,204	14,898	6,681	26,783	5,170	14,690	2,006	26,866
Haywood	4,284	10,647	3,343	18,274	4,178	10,306	3,644	18,128	4,063	10,047	3,864	17,974
Henderson	688'9	17,382	5,565	29,836	868'9	17,441	5,959	30,298	096′9	17,485	6,307	30,752
Henry	6,846	18,487	8,438	33,771	6,777	18,319	8,959	34,055	6,720	18,160	9,454	34,334
Lake	1,207	5,897	1,337	8,441	1,187	5,993	1,399	8,579	1,147	6,070	1,484	8,701
Lauderdale	6,631	17,975	4,324	28,930	6,580	18,028	4,578	29,186	6,524	18,100	4,796	29,420
McNainy	5,921	15,605	5,960	27,486	5,860	15,572	6,328	27,760	5,796	15,549	6,685	28,030
Madison	25,039	62,214	17,546	104,799	25,201	62,208	18,943	106,352	25,487	62,090	20,326	107,903
Obion	6,706	18,348	6,571	31,625	6,619	18,043	6,897	31,559	6,584	17,727	7,171	31,482
Tipton	16,996	42,277	996'6	69,239	17,157	42,995	11,044	71,196	17,294	43,822	12,025	73,14.1
Weakley	7,017	22,513	6,770	36,300	6,975	22,266	7,119	36,360	7,025	21,869	7,438	36,332
TN SSA Subtotal	398,433	990,259	253,442	1,642,134	400,650	988, 196	272,188	1,661,034	402,891	983,682	290,610	1,677,183
Critenden (AR)	13,203	29,694	6,323	49,402	12,713	29,557	6,587	49,039	12,346	29,454	6,785	48,675
Lawrence (AR)	3,692	9,754	3,396	16,905	3,601	9,641	3,476	16,780	3,533	9,556	3,536	16,656
DeSoto (MS) /	46,645	108,832	21,432	174,134	47,316	112,145	22,996	179,683	47,819	114,630	24,169	185,231
Marshall (MS) /	7,677	22,612	5,726	36,138	7,368	22,365	6,035	35,891	7,136	22,180	6,267	35,645
Benton (MS)	1,897	5,075	1,389	8,397	1,818		1,373	8,324	1,759		1,361	8,252
AR/MS SSA Subtotal	73,114	175,967	38,266	284,976	72,816		40,467	289,717	72,593		42,118	294,459
SSA Total	471,547	1,166,226	291,708	1,927,110	473,466	1,167,001	312,655	1,950,751	475,484	1,164,616	332,728	1,971,642
PSA + SSA Total	721,294	1,761,302	417,097	2,897,322	725,778	1,760,477	447,889	2,931,773	730,110	1,754,771	477,715	2,961,410
			NO STATE OF									
PSA Need @ 30/100K				291.1				294.3				296.9
SSA Need @ 30/100K				578.1				585.2				591.5
Total Need @ 30/100K				869.2				879.5				888.4

Sources: (1) The University of Tennessee Center for Business and Economic Research, Population Projection Data Files.

Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment.

(2) ACS Demographic & Housing Estimates, 2010-2015 American Community Survey 5-year estimates, U.S. Census Bureau. Cohort totals for 2017-2021 developed from straight-line projection of 2010 & 2015 Census Bureau cohort totals.

Note: These data may not match the University of Tennessee data exactly due to rounding.

- 2. Additional Factors: An applicant shall address the following factors:
 - a. The willingness of the applicant to accept emergency involuntary and nonemergency indefinite admissions;

Response:

The applicant does accept emergency involuntary admissions.

b. The extent to which the applicant serves or proposes to serve the TennCare population and the indigent population;

Response:

In 2017, Crestwyn had a TennCare/Medicaid payor mix of approximately 46% and a charity care payor mix of approximately 1%.

c. The number of beds designated as "specialty" beds (including units established to treat patients with specific diagnoses);

Response:

There are no specialty bed unit designations at Crestwyn. There are four program divisions, two for adults, one for children (10-12) and adolescents, and one for dual diagnosis patients.

d. The ability of the applicant to provide a continuum of care such as outpatient, intensive outpatient treatment (IOP), partial hospitalization, or refer to providers that do;

Response:

The applicant has a strong and expanding continuum of inpatient and outpatient services. Inpatients after discharge typically enter a step-down Partial Hospitalization Program (PHP) 5 hours per day, 5 days per week. There is also an Intensive Outpatient Program (IOP) with three group sessions per day, which is conducted on either a 3-day or 5-day span of time. If discharged patients have personal or job-related conflicts with participating in the PHP program, they may enter the evening IOP program.

At the present time, Crestwyn is organizing and recruiting medical leadership for a post-discharge outpatient program focused exclusively on alcohol and drug issues. It is projected to begin in the Fall of this year.

e. Psychiatric units for patients with intellectual disabilities;

Response:

To be admitted, a patient must demonstrate sufficient cognitive abilities to participate in both individual and group therapy. The facility's psychiatrists and clinical

teams will make that judgment using a Behavioral Health Assessment, not an arbitrary IQ standard.

f. Free standing psychiatric facility transfer agreements with medical inpatient facilities;

Response:

Crestwyn is partnered with two co-owning general acute care hospital systems--Baptist and Saint Francis. Crestwyn has patient transfer agreements with both.

g. The willingness of the provider to provide inpatient psychiatric services to all populations (including those requiring hospitalization on an involuntary basis, individuals with co-occurring substance use disorders, and patients with comorbid medical conditions); and

Response:

The applicant provides short-term acute inpatient care to patients requiring hospitalization on an involuntary basis, and individuals with co-occurring substance abuse issues. It provides transfers to Baptist Hospital, for patients who require acute inpatient medical care.

h. The applicant shall detail how the treatment program and staffing patterns align with the treatment needs of the patients in accordance with the expected length of stay of the patient population.

Response:

The facility serves short-stay acute patients diagnosed with a psychiatric condition. 2017 average lengths of stay were 10.3 days overall. That was comprised of 10.5 days for adults, 10.8 days for patients 17 years of age or younger, and 8.0 days for dual diagnosis patients.

Excluding dual diagnosis patients, ALOS for all psychiatric programs averaged 10.5 days.

i. Special consideration shall be given to an inpatient provider that has been specially contracted by the TDMHSAS to provide services to uninsured patients in a region that would have previously been served by a state operated mental health hospital that has closed.

Response:

Not applicable to the primary service area or to this applicant.

j. Special consideration shall be given to a service area that does not have a crisis stabilization unit available as an alternative to inpatient psychiatric care.

Response:

The service area has two TennCare-designated Crisis Stabilization teams--Youth Villages and Alliance--both of which support this project.

3. Incidence and Prevalence: The applicant shall provide information on the rate of incidence and prevalence of mental illness and substance use within the proposed service area in comparison to the statewide rate. Data from the TDMHSAS or the Substance Abuse and Mental Health Services Administration (SAMHSA) shall be utilized to determine the rate. This comparison may be used by the HSDA staff in review of the application as verification of need in the proposed service area.

Rationale: The rate of incidence and prevalence of mental illness in the service area may indicate a need for a higher number of psychiatric inpatient beds in the designated area.

Response:

The applicant has consulted in the past with planning staff at the TDMHSAS, who knew of no source of such data that could be used to project need for inpatient psychiatric beds.

4. Planning Horizon: The applicant shall predict the need for psychiatric inpatient beds for the proposed first two years of operation.

Rationale: The Division believes that projecting need two years into the future is more likely to accurately reflect the coming trends and less likely to overstate potential future need.

Response:

Crestwyn's operational projections in this application extend to Year Five of the project's operation, which will be CY2023.

The response to Standard 1 in this section includes projected service area bed needs in CY2020 and CY2022, using the State Health Plan methodology.

5. Establishment of Service Area: The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The proposal's sensitivity and responsiveness to the special needs of the service area shall be considered, including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, other medically underserved populations, and those who need services involuntarily. The applicant may also include information on patient

origination and geography and transportation lines that may inform the determination of need for additional services in the region.

Applicants should be aware of the Bureau of TennCare's access requirement table, found under "Access to Behavioral Health Services" on pages 93-94 at http://www.tn.gov/assets/entities/tenncare/attachments/operationalprotocol.pdf.

Rationale: In many cases it is likely that a proposed psychiatric facility's service area could draw more significantly from only a portion of a county. When available, the Division would encourage the use of sub-county level data that are available to the general public (including utilization, demographic, etc.) to better inform the HSDA in making its decisions. Because psychiatric patients often select a facility based on the proximity of caregivers and family members, as well as the proximity of the facility, factors other than travel time maybe considered by the HSDA. Additionally, geography and transportation lines may limit access to services and necessitate the availability of additional psychiatric inpatient beds in specific service areas.

Response:

The applicant is an existing hospital with an established service area and payor mix, which are the basis for the application's projected service area and payor mix. These document Crestwyn's broad accessibility to the groups named in this standard. It would be inappropriate to project a different service area or payor mix, based on purely demographic and socio-economic data.

6. Composition of Services: Inpatient hospital services that provide only substance use services shall be considered separately from psychiatric services in a CON application; inpatient hospital services that address co-occurring substance use/mental health needs shall be considered collectively with psychiatric services. Providers shall also take into account concerns of special populations (including, e.g., supervision of adolescents, specialized geriatric, and patients with comorbid medical conditions).

This project will decrease the applicant's complement of dual diagnosis beds in response to experience with its admissions. However, the application complies with this standard by considering its psychiatric and dual diagnosis patients' needs collectively in application of planning methodologies.

The composition of population served, mix of populations, and charity care are often affected by status of insurance, TennCare, Medicare, or TriCare; additionally, some facilities are eligible for Disproportionate Share Hospital payments based on the amount of charity care provided, while others are not. Such considerations may also result in a prescribed length of stay.

Rationale: Because patients with psychiatric conditions often experience co-morbid conditions, it is important that providers be capable of addressing such patients' potential medical needs. The accessibility of psychiatric services to various

populations and for appropriate lengths of stay are important considerations for the HSDA when reviewing psychiatric inpatient services applications.

Response:

Crestwyn is accessible to all of these patient populations. Crestwyn is contracted with all three of its area's TennCare MCO's and also with Medicaid in other States. Services to TennCare and indigents are reflected in its payor mix and in its Projected Data Chart. Crestwyn's 10.3 day average length of stay is slightly below the average for Memphis psychiatric hospitals as reported in their 2016 JAR's (11.0) and well below the average length of stay for rural West Tennessee behavioral units and hospitals (23.0).

7. Patient Age Categorization: Patients should generally be categorized as children (0-12), adolescents (13-17), adults (18-64), or geriatrics (65+). While an adult inpatient psychiatric service can appropriately serve adults of any age, an applicant shall indicate if they plan to only serve a portion of the adult population so that the determination of need may be based on that age-limited population. Applicants shall be clear regarding the age range they intend to serve; given the small number of hospitals who serve younger children (12 and under), special consideration shall be given to applicants serving this age group. Applicants shall specify how patient care will be specialized in order to appropriately care for the chosen patient category.

Rationale: Based on stakeholder input, the Division has categorized the patient population into children, adolescents, adults, and geriatric. Each age category may require unique care.

Response:

This licensed and accredited facility provides distinct and appropriate care programs for all of the above age cohorts, except that it does not routinely serve children 12 years of age or younger. At the request of Youth Villages (The area's TennCare-designated crisis intervention organization) Crestwyn has admitted 10-12 year old children as special cases at TennCare's request, but not frequently. Ages 10-12 are considered "bridge years" between childhood and adolescence. Regulations do not prohibit children of that age rooming with an adolescent who is within two years of the child's age, if approved by the medical staff and the child's family.

8. Services to High-Need Populations: Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are involuntarily committed, uninsured, or low-income.

Response:

Crestwyn serves all of these groups. Its payor mix last year was approximately 46% TennCare/Medicaid and 1% charity.

9. Relationship to Existing Applicable Plans; Underserved Area and Populations: The proposal's relationships to underserved geographic areas and underserved population groups shall also be a significant consideration. The impact of the proposal on similar services in the community supported by state appropriations shall be assessed and considered; the applicant's proposal as to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, shall also be assessed and considered. The degree of projected financial participation in the Medicare and TennCare programs shall be considered.

Response:

The primary and secondary service areas for Crestwyn have two State hospitals (Memphis; Bolivar) who are funded to serve primarily indigent and long-term stay patients. These are different patient populations from those served by other Shelby County behavioral hospitals. This project will not adversely impact them. They did not oppose Crestwyn's original application and they are not expected to be concerned about this bed addition proposal.

The applicant participates heavily in TennCare and Medicare. Last year its payor mix on gross revenues for those patients was approximately 46% and 23%, respectively--a total of 69%.

Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall also include how the applicant's services may differ from existing services (e.g., specialized treatment of an age-limited group, acceptance of involuntary admissions, and differentiation by payor mix). Accessibility to specific special need groups shall also be discussed in the application.

Rationale: Based on stakeholder input, a number of factors, including occupancy, shall be considered in the context of general utilization trends. Additionally, several factors may be necessary to consider when determining occupancy including staffed beds verses licensed beds, the target patient population, and the operation of specialty units.

Response:

Trends in occupancy and utilization of other licensed mental health hospitals and psychiatric units of general hospitals are presented and discussed in Section B-Need-5 of the application. The applicant believes that in 2018, there are 969 staffed and available inpatient behavioral beds in the primary and secondary service area counties. The most recent utilization data for the Tennessee providers is CY 2016, when service area providers reported 839 staffed beds and 74.1% occupancy on staffed beds. See Section B-Need-5 for additional data on licensed beds, many of which are unavailable for patient care.

10. Expansion of Established Facility: Applicants seeking to add beds to an existing facility shall provide documentation detailing the sustainability of the existing facility. This documentation shall include financials, and utilization rates. A facility seeking approval for expansion should have maintained an occupancy rate for all

licensed beds of at least 80 percent for the previous year. The HSDA may take into consideration evidence provided by the applicant supporting the need for the expansion or addition of services without the applicant meeting the 80 percent threshold. Additionally, the applicant shall provide evidence that the existing facility was built and operates, in terms of plans, service area, and populations served, in accordance with the original project proposal.

Rationale: Based on stakeholder input, the implementation of an 80 percent threshold for the approval may serve as an indicator of economic feasibility for the expansion of the facility. The 80 percent occupancy requirement may limit an applicant's ability to add specialty services that require separation from other units. Examples include geriatric psychiatry, services for patients with co-occurring mental health needs and substance use disorders. Additionally, the majority of the programs in the state are currently operating under this threshold. The communities these programs serve may have needs that require an expansion of services. An applicant may provide evidence of the economic feasibility of expansion despite not operating at or above 80 percent of capacity.

Response:

Crestwyn is proposing to add only psychiatric beds; it is actually decreasing its dual diagnosis bed complement.

The CY2017 occupancy on the three psychiatric programs seeking to expand was 87.5%. The applicant has submitted historic financials (Historic Data Chart and its own financial statements) documenting that it has operated with a positive cash flow and a positive operating margin.

11. Licensure and Quality Considerations: Any existing applicant for this CON service category shall be in compliance with the appropriate rules of the TDH and/or the TDMHSAS. The applicant shall also demonstrate its accreditation status with the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or other applicable accrediting agency. Such compliance shall provide assurances that applicants are making appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems, and children who need quiet space). Applicants shall also make appropriate accommodations so that patients are separated by gender in regards to sleeping as well as bathing arrangements. Additionally, the applicant shall indicate how it would provide culturally competent services in the service area (e.g., for veterans, the Hispanic population, and LBGT population).

Response:

The applicant is licensed and accredited, and operates in compliance with all State and Federal rules. Appropriate age and gender separations are always observed. Seclusion rooms are provided. Services are provided with cultural sensitivity to all patients. Translation services are available telephonically.

12. Institution for Mental Disease Classification: It shall also be taken into consideration whether the facility is or will be classified as an Institution for Mental Disease (IMD). The criteria and formula involve not just the total number of beds, but the average daily census (ADC) of the inpatient psychiatric beds in relation to the ADC of the facility. When a facility is classified as an IMD, the cost of patient care for Bureau of TennCare enrollees aged 21-64 will be reimbursed using 100 percent state funds, with no matching federal funds provided; consequently, this potential impact shall be addressed in any CON application for inpatient psychiatric beds.

Response:

This hospital has an IMD classification. The project will expand child and adolescent bed complements while reducing total adult services (net difference in bed changes for the adult psychiatric and dual diagnosis programs). So the project will not adversely affect TennCare's cost-sharing with Federal Medicaid.

13. Continuum of Care: Free standing inpatient psychiatric facilities typically provide only basic acute medical care following admission. This practice has been reinforced by Tenn. Code Ann. § 33-4-104, which requires treatment at a hospital or by a physician for a physical disorder prior to admission if the disorder requires immediate medical care and the admitting facility cannot appropriately provide the medical care. It is essential, whether prior to admission or during admission, that a process be in place to provide for or to allow referral for appropriate and adequate medical care. However, it is not effective, appropriate, or efficient to provide the complete array of medical services in an inpatient psychiatric setting.

Response:

Crestwyn has transfer agreements in place with Baptist and St. Francis Hospitals, for the care of such patients with medical conditions that cannot be cared for at Crestwyn.

14. Data Usage: The TDH and the TDMHSAS data on the current supply and utilization of licensed and CON-approved psychiatric inpatient beds shall be the data sources employed hereunder, unless otherwise noted. The TDMHSAS and the TDH Division of Health Licensure and Regulation have data on the current number of licensed beds. The applicable TDH JAR provides data on the number of beds in operation. Applicants should utilize data from both sources in order to provide an accurate bed inventory.

Rationale: Using these sources for data is the only way to ensure consistency across the evaluation of all applications. Data provided by the TDH and the TDMHSAS shall be relied upon as the primary sources of data for CON psychiatric inpatient services applications. Each data source has specific caveats. Requiring the use of both licensed beds and operating beds will provide a more comprehensive bed inventory analysis.

Response:

The statistical data required for this application have been obtained from the Tennessee Department of Health's most current county-level population projections, Licensure reports, and Joint Annual Reports. The applicant is not aware that additional bed utilization data from TDMHSAS is needed for this particular project.

15. Adequate Staffing: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed Service Area. Each applicant shall outline planned staffing patterns including the number and type of physicians. Additionally, the applicant shall address what kinds of shifts are intended to be utilized (e.g., 8 hour, 12 hour, or Baylor plan). Each unit is required to be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times. This staffing level is the minimum necessary to provide safe care. The applicant shall state how the proposed staffing plan will lead to quality care of the patient population served by the project.

However, when considering applications for expansions of existing facilities, the HSDA may determine whether the existing facility's staff would continue without significant change and thus would be sufficient to meet this standard without a demonstration of efforts to recruit new staff.

Response:

This is an existing facility that conforms to the recommended staffing pattern. Crestwyn's nurses work 12-hour shifts (two per day) and its mental health techs (MHT) work 8-hour shifts (three per day). Units are always staffed with a minimum of 1 Nurse and 1 MHT per shift; and additional staff are utilized based on the acuity of the unit's census every day. For any patient who is at risk of harming him/herself or others, a dedicated MHT is assigned to be within arm's length of that patient 24/7 hat patient 24/7 at arm's length. The staffing table in Section B-Economic Feasibility-8 documents staffing projected for the facility.

16. Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care (e.g., agreements between freestanding psychiatric facilities and acute care hospitals, linkages with providers of outpatient, intensive outpatient, and/or partial hospitalization services). If they are provided, letters from providers (e.g., physicians, mobile crisis teams, and/or managed care organizations) in support of an application shall detail specific instances of unmet need for psychiatric inpatient services. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

Rationale: The Division recognizes that participation in community linkage plans is an important element in the provision of quality psychiatric inpatient services; therefore, it is important for applicants to demonstrate such connections with other community providers. The 2014 update to the State Health Plan moved from a primary emphasis of health care to an emphasis on "health protection and promotion". The development of primary prevention initiatives for the community advances the mission of the State Health Plan.

These linkages have been discussed in several responses to these standards and elsewhere in the application.

This application has received many strong support letters from community agencies and individuals who see the need for additional inpatient beds for troubled patients--especially younger persons (for whom this project will double Crestwyn's assigned bed complement). Their letters attest to Crestwyn's active involvement with their communities and their programs. Please read their letters in the Attachments to this document. Letters of support have been received from the following organizations and individuals thus far.

- 1. Youth Villages and Alliance Healthcare Services--These two organizations provide rapid-response assessment, evaluation, stabilization, and referral of children and adolescents who are experiencing a psychiatric emergency. They are the two designated resources for TennCare in the regional project service area, and have strong and continuing relationships with Crestwyn.
- 3. NAMI (National Alliance on Mental Illness)--a grass-roots advocacy organization dedicated to improving quality of life for persons with severe and persistent mental illness, and their families and communities. NAMI
- 4. Professional Care Services of West Tennessee--an agency of caring professionals who respond to mental health needs of their communities through assessment, intervention, treatment, rehabilitation, and support. PCS's six regional offices provide a broad range of outpatient services to adults and to children. They have multiple types of professionals available for their patients.
- 5. Serenity Recovery Centers--well-established across the Mid-South, this organization is one of the largest and most trusted names in assisting people with co-occurring disorders, and addictions. The Centers serve more than 700 persons annually.
- 6. Quinco Community Mental Health (Jackson)--an outpatient treatment resource for individuals with addiction problems.
- 7. First Step Recovery Centers--a nonprofit organization licensed by TDMHSAS.
- 8. Rep. Mark White, 83rd District, Tennessee General Assembly
- 9. Germantown Police Department
- 10. Bellevue Baptist Church

- 11. Revelation of Hope Counseling Services
- 12. Delta Medical Center
- 17. Access: The applicant must demonstrate an ability and willingness to serve equally all of the patients related to the application of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed service area.

Response:

The applicant's historic payor mix documents its accessibility to the general patient population, including low-income and elderly persons, and patients needing involuntary confinement.

18. Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. An applicant that owns or administers other psychiatric facilities shall provide information on their surveys and their quality improvement programs at those facilities, whether they are located in Tennessee or not.

Rationale: This section supports the State Health Plan's Fourth Principle for Achieving Better Health regarding quality of care.

Response:

Crestwyn and Acadia (one of its three owners and the managing entity) have robust and effective quality improvement programs that include outcome and process monitoring systems. Please see the Attachments for examples.

The applicant is a joint venture that does not own any other psychiatric facilities in the State. The Attachments include Crestwyn's accreditation surveys and licensure surveys.

19. Data Requirements: Applicants shall agree to provide the TDH, the TDMHSAS, and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response:

The applicant so agrees.

(CONCLUSION OF RESPONSES TO STATE HEALTH PLAN CRITERIA FOR SECTION B)

(SECTION B APPLICATION FORM QUESTIONS, CONTINUED)

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to previously approved projects of the applicant.

Crestwyn was organized as a joint enterprise between Acadia Healthcare and the Baptist and Saint Francis health systems of Memphis. They both strongly support Crestwyn's programs. Their jointly-owned facility received CON authorization to serve all age groups--adults, children, and adolescents. It was constructed with room to expand its bed complements without additional internal construction that could disrupt patient care in such a small facility.

After approximately one and a half years of operation, Crestwyn finished CY2017 with more than 86% occupancy on its adult psychiatric beds and more than 88% on its adolescent beds. In January 2018, the two programs combined operated at 98% occupancy.

However, its dual diagnosis admissions (patients with both psychiatric and substance abuse treatment needs) have not been as strong (33% occupancy in CY2017).

Crestwyn's five-year plan for this project therefore envisions re-assigning 5 dual diagnosis beds to its two psychiatric programs, and increasing the total facility complement by 14 beds. This will allow the dual diagnosis beds to operate at high efficiency (almost 87% in Year Four, CY2022). It will provide room for program growth in adult and adolescent programs, which are currently full and are turning away admissions requests for lack of bed availability. With demand trends continuing, Crestwyn anticipates reaching overall 82% occupancy in Year Two of this project (2020) and 90% occupancy in Year Five (2023).

So this application, which proposes to more completely utilize floor space that already exists, will help Crestwyn, and its partners at Baptist and Saint Francis, serve the patients their joint enterprise was approved to serve.

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3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area, using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the bordering states, if applicable.

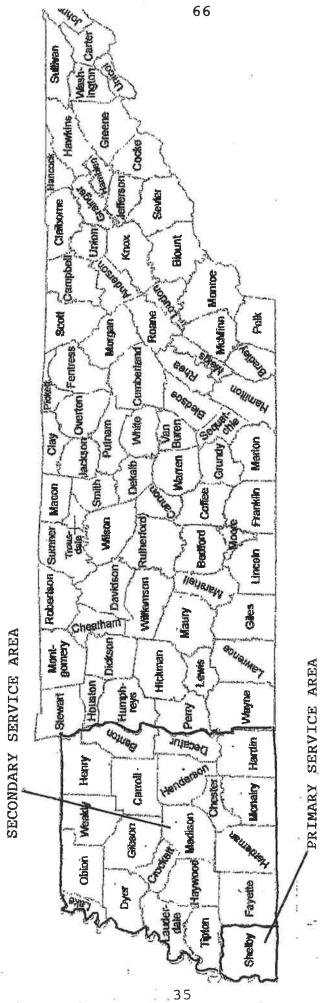
Crestwyn's original application in CY2015 projected a regional service area comprised of 68 counties in 3 States--with 86% of its admissions coming from 20 counties (10 Tennessee counties, 4 Mississippi counties, and 6 Arkansas counties).

In its first year of operation, Crestwyn's service area has been extensive. Approximately 95% of its patients came from 63 counties in three States. However, approximately 60% are from Shelby County, and no other Tennessee county contributes more than approximately 3%; most are 1% or less of admissions. Therefore with HSDA staff consent, Shelby County is being declared as the applicant's primary service area ("PSA") with a large number of other counties being included as secondary service area ("SSA") counties. Knox, Davidson, and Rutherford Counties contribute 9-11 annual admissions as well, but they generate less than 1% of admissions and are too distant to be declared within a contiguous secondary service area.

Tab	le A-3A(3)(a): Service Area (West TN and MS/AR)
	Primary Service	Area
	Shelby Count	у
	Secondary Service Are	a Counties
Benton	Dyer	Lake
Benton MS	Fayette	Lauderdale
Carroll	Gibson	Lawrence AR
Chester	Hardeman	Madison
Crittenden AR	Hardin	Marshall MS
Crockett	Haywood	McNairy
Decatur	Henderson	Obion
Desoto MS	Henry	Tipton

Based on first year patient origin at Crestwyn there will also be referrals from counties and States beyond these areas, comprising approximately 13% of admissions. Please see the patient origin table following the service area map.

CRESTWYN BEHAVIORAL HEALTH



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	R	Revised 3-20)-18		
			Cumulative Facility	County % of All	of All
COUNTY	STATE	Admissions	Admissions	Admissions	Admissions
Shelby	TN	790	790	59.5%	59.5%
DeSoto	MS	65	855	4.9%	64.4%
Tipton	TN	41	896	3.1%	67.5%
Madison	TN	31	927	2.3%	69.8%
Crittenden	TN	25	952	1.9%	71.7%
Carroll	TN	22	974	1.7%	73.3%
Gibson	TN	21	995	1.6%	74.9%
Lauderdale	TN	21	1,016	1.6%	76.5%
Marshall	TN	15	1,031	1.1%	77.6%
Fayette	TN	11	1,042	0.8%	78.5%
Knox	TN	11	1,053	0.8%	79.3%
Benton	TN	10	1,063	0.8%	80.0%
Davidson	TN	10	1,073	0.8%	80.8%
McNairy	TN	10	1,083	0.8%	81.6%
Weakley	TN	10	1,093	0.8%	82.3%
Dyer	TN	9	1,102	0.7%	83.0%
Hardeman	TN	9	1,111	0.7%	83.7%
Rutherford	TN	9	1,120	0.7%	84.3%
Henry	TN	8	1,128	0.6%	84.9%
Lawrence	TN	8	1,136	0.6%	85.5%
Putnam	TN	8	1,144	0.6%	86.1%
Crockett	TN	7	1,151	0.5%	86.7%
Henderson	TN	7	1,158	0.5%	87.2%
Maury	TN	6	1,164	0.5%	87.7%
Montgomery	TN	6	1,170	0.5%	88.1%
Obion	TN	6	1,176	0.5%	88.6%
77 Other <0.5%	TN & Others	152	1,328	11.4%	100.0%
TOTAL		1,328			

Source: Crestwyn Behavioral Health records.

3. (Continued) Please complete the following tables, if applicable:

Primary Service Area Counties	Applicant's Current Utilization From County (2016-17 Admissions)	% of Applicant's Utilization from County
Shelby	790	59.5%

	Projected Admissions To	
TN Primary Service Area	The Project in	
Counties	CY2019 (Year Two)	% of Total Admissions
Shelby	1,365	60%

4A(1). Describe the demographics of the population to be served by the proposal.

The second following page is additional demographic information on both the primary and secondary service area counties, in the format requested by HSDA projecting population growth to 2020. Its target population is the entire population because this applicant has been authorized to serve children, adolescent, and adult patients as bed space and appropriate treatment programs are available. Crestwyn has not yet admitted significant numbers of patients younger than 12, but intends to develop programs and facilities to serve more of those very young patients after Year Two of the project.

The demographic table on the following page shows these projections for the primary and secondary service areas of the project:

- The median age of the total service area is higher than the Tennessee State average; but the median age of Shelby County, the primary service area, is much younger--35.1 compared to 38.5 Statewide and 40.3 for the entire service area including Shelby County.
- Population growth for Shelby County and for the entire service area is approximately half that of Tennessee's.
- Shelby County, compared to the State of Tennessee, has apaproximately the same median income, but the service area as a whole has a significantly lower median income than the State's.
- Shelby County, the PSA, has a much higher percent of residents in TennCare/Medicaid, than does Tennessee: 26.5% compared to 21.2%. Shelby County has 21.4% of its residents living in poverty compared to 17.2% Statewide.

4A(2). Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the U.S. Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data:

http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data:

http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder:

http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Please see the table on the following page, which is compiled from these required sources.

				Demograț	Table Need	Table Need-4A(2): Project Name Demographic Characteristics of Primary Service Area 2018-2020	ect Name rimary Servi	ice Area					
	2		Department of Health / Health Statistics	f Health / Hea	Ith Statistics				Bureau of the Census	he Census		TennCare	
Primary Service Area	Current Total Population	Projected Total Population	Total Population % Change 2018 -	Current Target* Population All Ses	Projected Target* Population All Ages	Projected Target* Population % Change	Projected Target* Population As % of Projected Total Population	Wedian Age	Median Household Income	Persons Below Poverty Level as % of Total	Persons Below Poverty Level	Current TennCare	TennCare Enrollees as % of Total County or ZIp Code
Shelby / PSA	970.212	1			981,022	1.1%			\$46,854	21.4%	207,625	258,739	26.5%
													100
Benton	16,711					0.2%			\$33,611	22.6%	3,777	4,206	25.2%
Carroll	28,753		0.1%	28,753	28,782	70%	100.0%	42.8	\$36,212	19.8%	2,080	3 980	20.9%
Chester	10,033	15,970								1	2.742	3,831	25.6%
Decatur	12,029									20.9%	2,514	2,970	24.7%
Dver	39.607					0.7%	100.0%	40.3	\$42,833	18.6%	7,367	10,690	27.0%
Favette	46,608										6,991	7,065	15.2%
Gibson	51,934		3 1.0%		52,438	1.0%	100.0%		\$38,854		9,712		25.1%
Hardeman	27,284		%0.0	27,284					\$46,854	21.4%	5,839		25.7%
Hardin	26,680		3 0.4%							22.2%	5,923		27.6%
Haywood	18,274		98-0-	18,274	18,128					21.0%	3,838		30.5%
Henderson	29,836	30,298	1.5%					40.4			6,176	7,348	24.6%
Henry	33,771	34,055		33,771	34,055				\$38,378		6,558		23.6%
Lake	8,441	8,579	9 1.6%		8,579				1		2,465		26.0%
Lauderdale	28,930							37.6	\$32,353		7,146	7,834	27.1%
McNairy	27,486								-	23.1%	6,425	7,350	26.7%
Madison	104,799	Ì		-					1		20,331	28,841	27.5%
Objon	31,625										0L/'0	8,131	
Tipton	69,239							37.3	1		GGG'6	13,526	
Weakley	36,300					0.2%			1		6,933	7,243	
Crittenden (AR)	49,402									24.6%	12,153	na	na
Lawrence (AR)	16,905	16,780								23.6%	4,026		na
DeSoto (MS)	174,134	Ì	3 3.2%	-				36.2					na
Marshail (MS)	36,138												na
Benton (MS)	8,397			1			1						na
PSA + SSA Total	1,927,110		1.2%					40.3		19.7%	379,730	4 475 275	24.9%
State of TN Total		7,112,424		6,960,524	7,112,424	2.2%	100.0%		340,574		In 17'/61'I	010'014'1	71.7

Sources: TDOH Population Projections, 2015; U.S. Census QuickFacts; TennCare Bureau. Service area data are either total, or average, as appropriate.

4B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

This project's primary service area, from which 60% of its patients come, has a younger population, considerably more poverty, and a higher percentage of its population enrolled in TennCare than does the State of Tennessee overall. This project, by increasing the number of beds available to adolescents and some children, reflects the greater need of the primary service area for services to youth.

Crestwyn is very accessible to the elderly, women, racial or ethnic minorities, and low-income groups. Having more beds available at Crestwyn for all of these and other area residents will increase their access to the kind of care that is supported by community-based agencies across the service area. Thosse agencies working in the field have written favorably of the need for this project, so that the accessibility their clients have had to Crestwyn can continue.

5. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must provide the following data: admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the appropriate measures, e.g., cases, procedures, visits, admissions, etc. This does not apply to projects that are solely relocating a service.

The acute inpatient psychiatric care providers in the project's primary service area are listed below. The maps on the following pages show their locations, keyed to their numbers on the list. After the maps is a two-page table showing their available beds and utilization data for CY2013-CY2016. This table excludes facilities not filing a Joint Annual Report but notes to the table identify recent licensed bed additions. Current utilization data for the sole out-of-State provider in the service area is not available to the applicant.

Shelby County

- 1. Behavioral Healthcare Center at Memphis (new last year) 1505 North Second Street, Memphis, TN 38107
- 2. Crestwyn Behavioral Health

9485 Crestwyn Hills Cove, Memphis, TN 38125

3. Delta Medical Center

3000 Getwell Road, Memphis, TN 38118

- 4. Lakeside Behavioral Health
 - 2911 Brunswick Road, Memphis, TN 38133
- 5. Memphis Mental Health Institute (State Hospital)

951 Court Avenue, Memphis, TN 38103

6. Methodist Healthcare

1265 Union Avenue, Memphis, TN 38104

7. St. Francis Hospital

5959 Park Avenue, Memphis, TN 38119

Other West Tennessee Counties

- 8. Baptist Memorial Huntingdon Hospital (Carroll County)
 - 631 R.B. Wilson Drive, Huntingdon, TN 38344
- 9. Behavioral Healthcare Center at Martin (Weakley County)

458 Hannings Lane, Martin, TN 38237

- 10. Henry County Medical Center (Henry County)
 - 301 Tyson Avenue, Paris, TN 38242
- 11. Pathways of Tennessee (Madison County)
 - 238 Summar Drive, Jackson, TN 38301
- 12. Western Mental Health Institute (State Hospital) (Hardeman County)

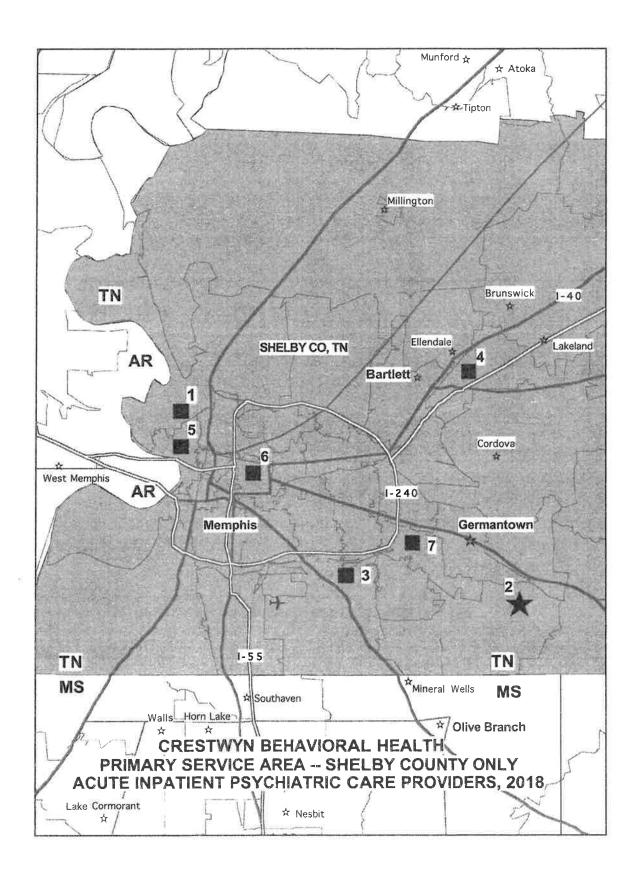
11100 Old Highway 643 West, Bolivar, TN 38008

13. Woodridge of West TN dba Oak Hills Behavioral Center (Madison County)

49 Old Hickory Boulevard, Jackson, TN 38305

Mississippi (No facilities in Arkansas Secondary Service Area)

Parkwood Behavioral Health (DeSoto County)
 8135 Goodman Road, Olive Branch, MS 38654



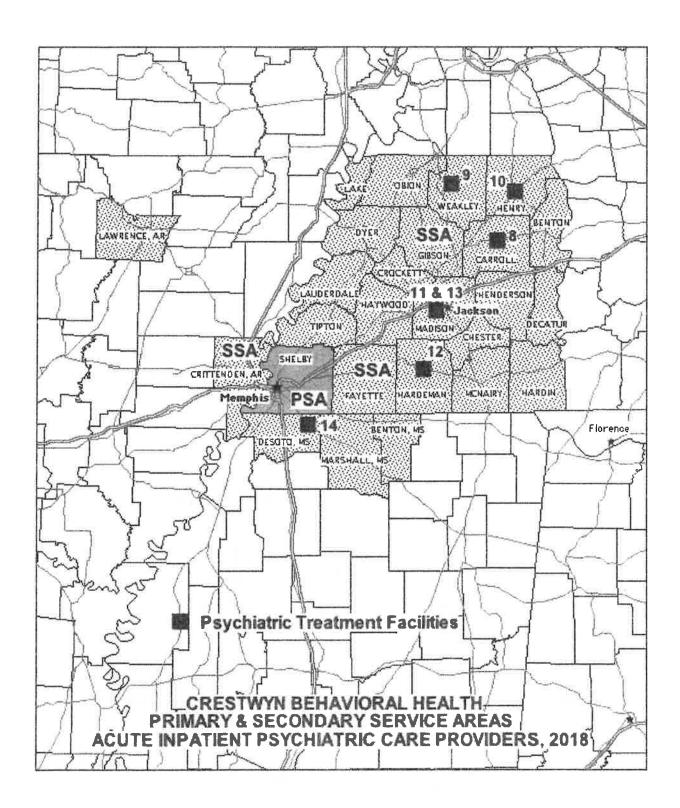


Table Need-5 (Page 1):	Psychiatr		lization ii 4-2016	n Crestwy	n's Tenno	essee Se	rvice Are	a	
2014 Joint Annual Reports of Hospitals					T				0 000000
Facility Name	County	Staffed Psychiatric Beds	Assigned/ Licensed Psychiatric Beds	Behavioral Admissions	Behavioral Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds	Occupancy on Staffed Beds
Lakeside Behavioral Health System	Shelby	290	290	8,453	83,256	10	228	78,7%	78.7%
Memphis Mental Health Institute	Shelby	55	55	1,565	16,877	11	46	84.1%	84.1%
Delta Medical Center	Shelby	109		2,873		13	103	94.3%	94.3%
Methodist University Healthcarepsych beds	Shelby	34	34	441	8,467	19	23	68.2%	88.2%
St. Francis Hospital-psych beds	Shelby	102	102	1,384	11,502	8	32	30.9%	30.9%
Primary Service Area (Shelby County) Subtotal	Strate	590	590	14716		11	432	73.2%	73.2%
Filling Service Area (Shelby County) Subtown		- 000	- 500	147.10	101000			1 2 34 70	1 404.0
Western Mental Health Institute	Hardeman	150	187	1,012	43,483	43	119	63.7%	79.4%
Henry Co Medical Center	Henry	22		214	2,189	10	6	27.3%	27.3%
Pathways of Tennessee-psych beds	Madison	25		706	3,706	5	10		40.6%
Behavioral Healthcare Center at Martin	Weakley	16		231	4.274	19	12	73.2%	73.2%
TN Secondary Service Area Subtotal		213		2,163	53,652	25	147	58.8%	69.0%
TN Primary & Secondary SA Totals		803		16,879			579		72.1%
Anthrope Control of the Control of t	CONTRACTOR OF	A TRAINER	SON THE REAL PROPERTY.	a raine anna	200 2200	No. of the same		ALCOHOLD SECTION	
2015 Joint Annual Reports of Hospitals									
		Staffed Psychiatric	Assigned/ Licensed Psychiatric		Behavioral	Avg Length of Stay	Avg Daily Census	Occupancy on Licensed	
Facility Name	County	Beds	Beds	Admissions	Days	(Days)	(Patients)	Beds	Beds
Lakeside Behavioral Health System	Shelby	233		8,378	85,069	10	233	80.4%	100.0%
Memphis Mental Health Institute	Shelby	55	111	1,547	17,299	11	47	42.7%	86.2%
Delta Medical Center	Shelby	109		2,875		13	101	92.3%	92.3%
Methodist University Healthcare -psych beds	Shelby	34	34	388	7,791	20 9		62.8% 37.1%	37.1%
St. Francis Hospital-psych beds	Shelby	102 533	102 646	1,502 14,690	13,825 160,725	11	38 440		82.6%
Primary Service Area (Shelby County) Subtotal		555	040	14,020	160,723		:440	00,276	02.076
Baptist Memorial Huntingdon Hospital	Carroll	12	12	148	1,871	13	5	42.7%	42.7%
Western Mental Health Institute	Hardeman	150		1,046		45	128	68.6%	85.6%
Henry Co Medical Center	Henry	22	22	257	2,097	8	6		26.1%
Pathways of Tennessee-psych beds	Madison	25		753	3,245	4	9		35.6%
Behavioral Healthcare Center at Martin	Weakley	16		210		16			59.2%
TN Secondary Service Area Subtotal		225		2,414	57,523	24	158	60.2%	70.0%
TN Primary & Secondary SA Totals		758	908	17,104	218,248	13	598	65.9%	78.9%
			Subjection	or that are	RECORD TO				
2016 Joint Annual Reports of Hospitals								1	
Facility Name	County	Staffed Psychiatric Beds	Assigned/ Licensed Psychiatric Beds	Behavioral Admissions	Behavioral Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds	Occupancy on Staffed Beds
Crestwyn Behavioral Health	Shelby	30	60	635	6,104	10	25	41.7%	83.4%
Lakeside Behavioral Health System-psych beds	Shelby	337	345	8,719	86,239	10	236	68.5%	70.1%
Memphis Mental Health institute	Shelby	55		1,522	17,565	12	48	43.4%	87.5%
Delta Medical Center	Shelby	114					92	81.1%	81.1%
Methodist University Healthcarepsych beds	Shelby	34		370				59.1%	59.1%
St. Francis Hospital—psych beds	Shelby	40		1,457	11,790				80.8%
Primary Service Area (Shelby County) Subtotal		610			162,782				
Baptist Memorial Huntingdon Hospital	Carroll	7	12	157	1,437	9	4	32.8%	56.2%
Western Mental Health Institute	Hardeman	150				49			91.5%
		22		349		6			-
Henry County Medical Center	Henry	18		775		20			50.3%
Pathways of Tennessee—psych beds	Madison								59.5%
Woodridge of W TN dba Oak Hills Behavioral Center	Madison	16							
Behavioral Healthcare Center at Martin	Weakley	16				14			
TN Secondary Service Area Subtotal		229							
TN Primary & Secondary SA Totals	1	839	1,022	18,061	226,916	13	622	80.8%	74.1%

- 1. Crestwyn Behavioral Health Center was open approximately 8 months in 2016; occupancies on its beds calculated on 244 days.
- 2. 25 licensed beds are now occupied by SE Mental Health Center staff.
 3. Behavioral Healthcare Center at Memphis (1505 N. Second St) opened 16 beds in 2017; they are not yet reported in JAR data.
 4. St. Francis currently does not staff all of its reported psychiatric beds for psychiatric care.

	Table Need-5 (Page 2)								
	2017								
State	Facility Name	County	City	Licensed Psychiatric Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupand on License Beds
MS	Parkwood Behavioral Health System	DeSoto	Olive Branch	108	na	na	na	na	

Notes:
1. No Arkansas facilities in project service area.
2. Parkwood is the only psychiatric hospital in the primary service area. Mississippi does not publish utilization data more recent than 2013.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology <u>must include</u> detailed calculations or documentation from referral sources, and identification of all assumptions.

Historical Utilization

Crestwyn opened in the Spring of CY2016, and filled its beds rapidly. Table B-Need-6 on the following page provides its utilization by program, from May of 2016 through January of 2018.

In its first full year of operation, CY2017, Crestwyn experienced a remarkable average occupancy of 87.5% of its 49 psychiatric beds (all programs), and 33.3% occupancy of its dual diagnosis beds, for an overall occupancy of 73.5% ON 66 beds.

In January 2018, Crestwyn averaged 94.2% occupancy on its 49 psychiatric beds, and 79.3% overall (which included an underutilized dual diagnosis unit with only 36.2% occupancy.

All indicators are that while adding 14 more beds, Crestwyn also needs to increase its psychiatric bed complements (especially adolescent beds) while reducing the number of beds assigned to dual diagnosis patients. That is what this application proposes.

Projected Utilization

Table B-Need-6 also projects Crestwyn's utilization for CY2018 through CY2023, Year Five of the hospital after enlarging its complement to 80 beds.

Adult beds, heavily utilized at 86.9% in 2017, increased to 91.4% occupancy in early 2018. If this project is approved, Crestwyn expects 2018 admissions to be 12% above 2017, then to dip 5% in 2019 due to focusing of resources on the adolescent and outpatient programs, and then to increase 1% annually through 2023, Year Five of the increased bed complement.

Child and Adolescent beds, which surged to 100% occupancy in early 2018, are expected to see an admissions increase of 12.8% in 2018 (based on having new beds available by July 1), and then 50% higher admissions in 2019, followed by 10% growth in Year Two (2020) and then 3% for the next three years.

Dual diagnosis admissions are projected to increase from 235 admissions in 2017 to 282 in this year--an increase in 20% (but on small numbers). The following year, the projected increase will be 15%, and thereafter 10% annually for four more years.

Table Need-6	Table Need-6: Crestwyn Behavioral Health Utilization By Program 2017-2023								
WHING WATER TO SHE OF THE OWNER OWNER OF THE OWNER					Proje	cted			
	Last Year 2017	Jan '18 31 days	2018	Yr 1 2019	Yr 2 2020	Yr 3 2021	Yr 4 2022	Yr 5 2023	
CRESTWYN TOTAL BEDS	66	66	66	80	80	80	80	80	
Admissions	1,724	159	2,004	2,275	2,404	2,479	2,559	2,643	
Days	17,714	1,622	20,043	22,749	24,022	24,737	25,493	26,294	
ALOS on Admissions	10.3	10.2	10.0	10.0	10.0	10.0	10.0	9.9	
ADC on Admissions	48.5	52.3	54.9	62.3	65.6	67.8	69.8	72.0	
Occupancy on Admissions	73.5%	79.3%	83.2%	77.9%	82.0%	84.7%	87.3%	90.0%	
Adult & Geri Psychiatric Beds	33	33	33	36	36	36	36	36	
Admissions	995	89	1,149	1,092	1,103	1,114	1,125	1,136	
Days	10,469	935	11,724	11,138	11,249	11,362	11,476	11,590	
ALOS on Admissions	10.5	10.5	10.2	10.2	10.2	10.2	10.2	10,2	
ADC on Admissions	28.7	30.2	32.1	30.5	30.7	31.1	31.4	31.8	
Occupancy on Admissions	86.9%	91.4%	97.3%	84.8%	85.4%	86.5%	87.3%	88.2%	
Child and Adolescent Beds	16	16	16	32	32	32	32	32	
Admissions	494	49	573	859	945	973	1,002	1,032	
Days	5,179	496	5,840	8,760	9,636	9,925	10,223	10,530	
ALOS on Admissions	10.5	10.1	10.2	10.2	10.2	10.2	10.2	10.2	
ADC on Admissions	14.2	16.0	16.0	24.0	26.3	27.2	28.0	28.8	
Occupancy on Admissions	88.7%	100.0%	100.0%	75.0%	82.3%	85.0%	87.5%	90.1%	
Alcohol and Drug Beds	17	17	17	12	12	12	12	12	
Admissions	235	21	282	324	357	392	432	475	
Days	2,066	191	2,479	2,851	3,136	3,450	3,795	4,174	
ALOS on Admissions	8.8	9.1	8.8	8.8	8.8	8.8	8.8	8.8	
ADC on Admissions	5.7	6.2	6.8	7.8	8.6	9.5	10.4	11.4	
Occupancy on Admissions	33.3%	36.2%	40.0%	65.1%	71.4%	78.8%	86.6%	95.3%	
		O. C.							
	Last Year 2017	Jan 2018	2018	Yr 1 2019	Yr 2 2020	Yr 3 2021	Yr 4 2022	Yr 5 2023	
Combined Psychiatric Programs									
Beds	49	49	49	68	68	68	68	68	
Admits	1,489	138	1,722	1,951	2,048	2,087	2,127	2,169	
Days	15,648	1,431	17,564	19,898			21,698	22,120	
ALOS on Admissions	10.5	10.4	10.2	10.2	10.2	10.2		10.2	
ADC on Admissions	42.9	46.2	48.1	54.5	57.2	58.3		60.6	
Occupancy on Admissions	87.5%	94.2%	98.2%	80.2%	84.1%	85.8%	87.4%	89.1%	

Source: Hospital Management

ECONOMIC FEASIBILITY

- 1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.
- A. All projects should have a project cost of at least \$15,000 (the minimum CON Filing Fee), (See application instructions for Filing Fee.)
- B. The cost of any lease, The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
- C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
- D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

The Project Cost Chart is provided on the following page.

- E. For projects that include new construction, modification, and/or renovation documentation must be provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:
 - 1) A general description of the project;
 - 2) An estimate of the cost to construct the project; and
 - 3) A description of the status of the site's suitability for the proposed project;
 - 4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

Not applicable; the project involves no construction.

80 PROJECT COST CHART—CRESTWYN BEHAVIORAL HEAL--14 BED ADDITION

		"Surface
A.	Construction and equipment acquired by purchase:	
	 Architectural and Engineering Fees Legal, Administrative, Consultant Fees (Excl CON Filing Fee) Acquisition of Site Preparation of Site Total Construction Cost Contingency Fund Fixed Equipment (Not included in Construction Contract) Moveable Equipment (List all equipment over \$50,000	\$ 5,000 50,000 0 0 0 0 0 21,000
В,	Acquisition by gift, donation, or lease:	
	 Facility (inclusive of building and land) Building only Land only Equipment (Specify) Other (Specify) 	0 0 0 0
C.	Financing Costs and Fees:	
	 Interim Financing Underwriting Costs Reserve for One Year's Debt Service Other (Specify) 	0 0 0 0
D.	Estimated Project Cost (A+B+C)	76,000
Ε.	CON Filing Fee	15,000

F. Total Estimated Project Cost (D+E)

91,000

91,000

0

TOTAL \$____

Actual Capital Cost

Section B FMV

2. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

A. Commercial LoanLetter from lending institution or guarantor stating tavoral initial contact, proposed loan amount, expected interest rates, anticipated term of the loan and any restrictions or conditions;	
B. Tax-Exempt Bondscopy of preliminary resolution or a letter from the issuiauthority, stating favorable contact and a conditional agreement from an underwriter investment banker to proceed with the issuance;	
C. General Obligation Bonds-Copy of resolution from issuing authority or minute from the appropriate meeting;	te:
D. GrantsNotification of Intent form for grant application or notice of grant award	l;
xE. Cash ReservesAppropriate documentation from Chief Financial Officer; or	
F. OtherIdentify and document funding from all sources.	

This very small project cost will be borne by the applicant hospital itself, using lines of credit available to it (see Long Term Debt on the balance sheet). Attachment B-Economic Feasibility-2 contains a letter from the Crestwyn Chief Financial Officer, committing to its availability. The hospital's income statement and balance sheet are provided in the Attachments to the application.

3. Complete Historical Data Charts on the following pages--Do not modify the Charts or submit Chart substitutions!

Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. Only complete one chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

The Historical Data Chart for Crestwyn is provided on the following two pages.

X TOTAL FACILITY

PROJECT ONLY

HISTORICAL DATA CHART -CRESTWYN BEHAVIORAL HEALTH

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in January.

Α.	Utilization Data (Specify unit or measure)	Admissions Patient Days			656 6,360	-	CY 2017 1,724 17,714
В.	Revenue from Services to Patients						
	 Inpatient Services 		\$	\$	9,154,500	\$_	26,569,500
	Outpatient Services		A		352,850	_	1,619,450
	Emergency Services				0	-	0
	4. Other Operating Revenue		***	-	281,275	-	480,792
	(Specify) See notes page						
		Gross Operating Revenue	\$0	\$	9,788,625	\$_	28,669,742
C.	Deductions from Gross Operating Rev	venue					
	 Contractual Adjustments 		\$	\$	6,221,933	\$	14,851,656
	Provision for Charity Care				54,504	-	329,869
	Provisions for Bad Debt				107,300	_	833,317
		Total Deductions	\$0	\$	6,383,737	\$_	16,014,842
NET	OPERATING REVENUE		\$0	\$	3,404,888	\$_	12,654,900
D.	Operating Expenses						
	 Salaries and Wages 						
	a. Clinical		\$	\$	1,158,293	\$	3,100,922
	b. Non-Clinical		,	-	1,663,783	_	2,563,678
	2. Physicians Salaries and Wages			-		-	0
	3. Supplies			MATERIAL PROPERTY.	298,487		438,481
	4. Rent						
	c. Paid to Affiliates			-		_	
	d. Paid to Non-Affiliates			_	19,152	-	44,375
	5. Management Fees						
	a. Paid to Affiliates					-	
	b. Paid to Non-Affiliates			-	House of the form of	-	
	Other Operating Expenses	See notes page.			2,150,639	_	4,817,896
		Total Operating Expenses	\$0	\$	5,290,354	\$	10,965,352
E.	Earnings Before Interest, Taxes, and	Depreciation	\$0	\$	(1,885,466)	\$	1,689,548
E.	Non-Operating Expenses						
	1. Taxes		\$		278	-	
	2. Depreciation		***************************************		539,828	-	831,996
	3. Interest				912,469	-	936,757
	4. Other Non-Operating Expenses					_	(108,996)
	To	otal Non-Operating Expenses	\$0	\$	1,452,575	\$_	1,659,757
NET	INCOME (LOSS)		\$0	\$	(3,338,041)	\$_	29,791
Chai	rt Continues Onto Next Page		-4				

			NA	C	Y 2016 (Partial)		CY 2017
NET	INCO	ME (LOSS)	\$ 	\$_	(3,338,041)	\$	29,791
G.	Oth	er Deductions					
	1.	Annual Principal Debt Repayment	\$	\$_	35,650	\$_	1,085,109
	2.	Annual Capital Expenditure		- 2	24,212,582		(493,440)
		Total Other Deductions	\$ 0	\$	24,248,232	\$	591,669
		NET BALANCE	\$ 0	\$	(27,586,273)	\$_	(561,878)
		DEPRECIATION	\$	\$	539,827	\$_	831,995
		FREE CASH FLOW (Net Balance + Depreciation)	\$ 0	\$_	(27,046,446)	\$_	270,117

X TOTAL FACILITY

O PROJECT ONLY

HISTORICAL DATA CHART - OTHER EXPENSES

OTI	HER EXPENSES CATEGORIES	NA	С	Y 2016 (Partial)		CY 2017
1.	Benefits	\$	\$_	505,005	\$	1,095,339
2.	Contract Labor			9,395		170,338
3.	Purchase Svcs			293,498	-	558,793
4.	Professional Fees			381,566		1,203,250
5.	Utilities			146,040		228,081
6.	Repairs and Maintenance			56,547		104,150
7.	Insurance Expense			401,264		169,405
8.	Marketing Expense			38,684	-	104,053
9.	Enterprise Growth			0		108,996
10.	Other Operating Expense			318,640		1,075,491
11.						
12.						
13.	****					
14						
15.						
	Total Other Expenses	\$ C	\$_	2,150,639	\$	4,817,896

3. Complete Projected Data Charts on the following pages - Do not modify the Charts provided or submit Chart substitutions!

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. Only complete one chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

X TOTAL FACILITY
O PROJECT ONLY

PROJECTED DATA CHART —CRESTWYN BEHAVIORAL HEALTH

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in January.

The	пѕса	i year begins in January.		CY 2019		CY 2020
				(Year One)		(Year Two)
A.	I Itil	ization Data	Admissions	2,275		2,404
,		ecify unit or measure)	Patient Days	22,749	-	24,022
	(- -			***************************************	•	
B.	Rev	enue from Services to Patients				
	1.	Inpatient Services		\$ 36,898,878	\$_	40,140,762
	2.	Outpatient Services		2,614,500	144	2,745,225
	3.	Emergency Services				
	4.	Other Operating Revenue		24,000		25,200
		(Specify) See notes page				
			Gross Operating Revenue	\$ 39,537,378	\$_	42,911,187
C.	Ded	luctions from Gross Operating Rev	venue			
•	1.	Contractual Adjustments		\$ 21,859,527	\$	24,122,228
	2.	Provision for Charity Care		395,134	-	428,860
	3.	Provisions for Bad Debt		790,268		857,720
			Total Deductions	\$ 23,044,928	\$	25,408,807
NET	OPER	RATING REVENUE		\$ 16,492,450	\$	17,502,380
D.		erating Expenses		13,733,733	-	,
٥.	1.	Salaries and Wages				
		a. Clinical		\$ 4,051,529		4,278,247
		b. Non-Clinical		2,835,244	0)-	2,948,653
	2.	Physicians Salaries and Wages			1	
	3.	Supplies		645,338	_	701,894
	4.	Rent			0.	
	'-	c. Paid to Affiliates				
		d. Paid to Non-Affiliates		58,433	0)	63,554
	5.	Management Fees		,	_	
		a. Paid to Affiliates				
		b. Paid to Non-Affiliates			1/	
	6.	Other Operating Expenses	See notes page	5,386,733	-	5,727,718
			Total Operating Expenses	\$ 12,977,276	\$	13,720,065
Ė.	Earr	nings Before Interest, Taxes, and I		\$ 3,515,174	\$_	3,782,315
г.	Ni	Operating Eventure				
F,		-Operating Expenses Taxes		\$	\$	
	1.				ა —	965 630
	2. 3.	Depreciation		860,768		865,630
		Other Non Operating Eventson		944,126		972,450
	4.	Other Non-Operating Expenses To	ital Non-Operating Expenses	\$ 1,804,894	\$_	1,838,080
		(, 222)				
		ME (LOSS)		\$1,710,280	\$ _	1,944,235
Char	t Cor	ntinues Onto Next Page				

				CY 2019		CY 2020
NET	INCO	ME (LOSS)	\$_	1,710,280	\$ _	1,944,235
G.	Oth	er Deductions				
	1.	Annual Principal Debt Repayment	\$	1,085,109	\$_	1,085,109
	2.	Annual Capital Expenditure		164,925		175,024
		Total Other Deductions	\$	1,250,034	\$	1,260,133
		NET BALANCE	\$	460,247	\$_	684,103
		DEPRECIATION	\$	860,768	\$_	865,630
		FREE CASH FLOW (Net Balance + Depreciation)	\$	1,321,015	\$_	1,549,733

X TOTAL FACILITY

O PROJECT ONLY

PROJECTED DATA CHART - OTHER EXPENSES

OTH	HER EXPENSES CATEGORIES	CY 2019	CY 2020
1.	Benefits	\$1,409,877\$	1,479,508
2.	Contract Labor		
3.	Purchase Svcs	754,747	820,890
4.	Professional Fees	1,377,159	1,497,849
5.	Utilities	349,700	380,347
6.	Repairs and Maintenance	156,407	170,114
7.	Insurance Expense	198,904	204,871
8.	Marketing Expense	91,036	93,767
9.	Enterprise Growth	115,669	119,139
10.	Other Operating Expense	933,235	961,232
11.			
12.			
13.			
14) 		
15.			
	Total Other Expenses	\$ 5,386,733 \$	5,727,718

5.A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Project	Project			% Change
	Previous	Current	Project	Project	(Current
	Year	Year	Year One	Year Two	Yr to Yr2)
Gross Charge Gross Operating IP	\$16,630		\$17,379	\$17,850	+2.7%
Revenue / ADMISSION		NA			
Revenue / DAY	\$1,618		\$1,738	\$1,786	+2.8%
Deduction from Revenue Total	\$9,289		\$10,130	\$10,569	+4.3%
Deductions / ADMISSION		NA			
Deductions / DAY	\$904		\$1,013	\$1,058	+4.4%
Average Net Charge Net	\$7,340		\$7,249	\$7,281	+0.4%
Operating Rev / ADMISSION		NA			
Operating Rev / DAY	\$714		\$725	\$729	+0.6%

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

The response to question 5C on the following page includes a table with current and projected charges for the most common DRG's at Crestwyn, together with the current Medicare reimbursement for each.

This project will not cause any charge increases at Crestwyn, because it involves a very small capital expenditure that will not create new debt service, and it will permit a significant revenue increase as space constraints on admissions are lifted by new bed capacity coming on line.

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Please see Table Economic Feasibility-5C on the following page for information about proposed charges at Crestwyn for frequent admissions DRG's

Below is a table comparing Crestwyn's projected 2019 charges to the 2016 charges reported in the Joint Annual Reports of other area facilities. There is not JAR revenue information specific to behavioral health units of general hospitals, so the table includes only behavioral health hospitals in the Tennessee service area.

Ta	ble Eco	onomic F	easibility-5C:	Charge Com	parisons	
Hospital	Year	IP Days	Gross IP Revenue	Net IP Revenue	Gross Rev. Per Day	Net Rev. Per Day
Lakeside Behavioral Health, Memphis	2016	78,173	\$165,878,934	\$62,122,510	\$2,122	\$795
Pathways of Tennessee, Jackson	2016	3,304	\$2,974,056	\$586,153	\$901	\$177
Woodridge/Oak Hills, Jackson	2016	3,475	\$5,179,776	\$2,609,444	\$1,491	\$751
Crestwyn Behavioral Health	2017	17,714	\$26,659,500	na	\$1,505	na
Crestwyn Behavioral Health	2019	22,749	\$36,898,878	na	\$1,622	na

Source: Joint Annual Reports, 2016 and application's Historic and Projected Data Charts. Note: Lakeside reported only total gross revenue that may include outpatient revenue.

				Average Gross Charge				е	
DRG	Descriptor	D	g Per liem wable		urrent Year 2018		Project ir 1 2019		roject r 1 2020
57	Degenrative nervous system disorders without mcc	\$	691	\$	1,575	\$	1,622	\$	1,671
776	Postpartum and post abortion diagnoses without O.R. procedure	\$	691	\$	1,575	\$	1,622	\$	1,671
880	Acute adjustment reaction and psychosocial dysfunction	\$	691	\$	1,575	\$	1,622	\$	1,671
881	Depressive neuroses	\$	691	\$	1,575	\$	1,622	\$	1,671
882	Neuroses except depressive	\$	691	\$	1,575	\$	1,622	\$	1,671
884	Organic disturbances and intellectual disability	\$	691	\$	1,575	\$	1,622	\$	1,671
885	Psychoses	\$	691	\$	1,575	\$	1,622	\$	1,671
886	Behavioral and developmental disorders	\$	691	\$	1,575	\$	1,622	\$	1,671
894	Alcholol, drug abuse or dependence	\$	691	\$	1,575	\$	1,622	\$	1,671
896	Alcohol, drug abuse or dependence w/o rehab therapy with mcc	\$	691	\$	1,575	\$	1,622	\$	1,671
897	Alcohol, drug abuse or dependence w/o rehab therapy without mcc	\$	691	\$	1,575	\$	1,622	\$	1,671

6.A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Crestwyn currently has a positive cash flow and a positive operating margin. This project requires no new debt service and is projected to lead to a significant increase in revenues, so the hospital will continue to have a positive cash flow and operating margin when the bed addition is implemented.

Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project.

Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as <u>Attachment C, Economic Feasibility</u>. NOTE: Publicly held entities only need to reference their SEC filings.

See Attachment Section B-Economic Feasibility-6A.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

	2 nd Yr Previous to Current Yr	1 st Yr Previous to Current Yr	Current Yr	Projected Yr 1	Projected Yr 2
Net Operating					
Margin Ratio		0.134	.200	0.213	0.216

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C. Capitalization Ratio (Long-term debt to capitalization) — Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt + Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Net Assets \$11,668,504 Long Term Debt \$15,827,658 \$27,496,162

15,827,658/27,496,162 = .5756 XX 100 = 57.56.

Source: Acadia Healthcare 10K for 2016 (audited)

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22. Section B, Economic Feasibility, Item 7, Page 61

Please complete the following chart for Year One of the proposed project. Please use the Project Only Projected Data Chart to obtain the gross revenue amount.

Payor	Gross Revenue	% of Total Revenues
Medicare/Medicare Managed Care	\$932,447	22.5%
Medicaid/TennCare	\$1,918,769	46.3%
Commercial insurance/Other Mgd Care	\$1,147,946	27.7%
Self-Pay	\$33,154	0.8%
Charity Care	\$37,298	0.9%
Other	\$74,596	1.8%
Total	\$4,144,210	100.0%

23. Section B, Orderly Development, Item 1 (Transfer Agreements), Page 64

Your response to this item is noted. Please indicate if the applicant has transfer agreements with Memphis Mental Health Institute and Western Mental Health Institute.

The applicant does not have transfer agreements with those two hospitals.

24. Section B, Orderly Development, Item 1 (Transfer Agreements), Page 66

Please provide the referenced state licensure survey information in Attachment Section B-Orderly Development-4B.

This is being gathered for submittal under separate cover.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Projected Payor Mix, Year 1						
Payor Source	Projected Gross Operating Revenue	As a Percent of Total Revenue				
Medicare/Medicare Managed Care	\$8,895,910	22.5%				
TennCare/Medicaid	\$18,305,806	46.3%				
Commercial/Other Managed Care	\$10,951,854	27.7%				
Self-Pay	\$316,299	0.8%				
Charity Care	\$355,836	0.9%				
Other	\$711,673	1.8%				
Total	\$39,537,378	100.0%				

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTE) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

See the staffing table on the following page, which provides this data.

Table Projected Additional Staff	Need-12: Cres Required for 1	Need-12: Crestwyn Behavioral Health Required for 14-Bed Expansion (Revis	e Need-12: Crestwyn Behavioral Health If Required for 14-Bed Expansion (Revised on Supplemental)	pplemental)
Position Classification	Existing FTEs (NA)	Projected FTEs (Yr 1)	Average Annual Salary (Contractual Rate)	Areawide / Statewide Average Salary
A. Direct Patient Care Positions Montal Health Tach (MHT)	37.80	42 00	479 120	\$20 170
Nurse (RN)		16.23	\$70,720	\$58,410
Master's Level Clinician	5.24	6,64	\$50,000	
Total Direct Patient Care Positions	56.74	64.87		
B. Non-Patient Care Positions				
1 1	1.60	2.00	000′59\$	not available
Total Non-Patient Care Positions	1.60	2.00		
Total Employees (A + B)	58.34	1 66.87		
C. Contractual Staff	2.33	2.60		:42
Total Staff (A+B+C)	(0.67	(69.47		al
Source: Crestwyn management.		Tr.		7, n

- 9. Describe all alternatives to this project that were considered and discuss the advantages and disadvantages of each alternative, including but not limited to:
- A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

The benefit intended by the proposal is an increase in inpatient psychiatric beds desired by many mental health agencies supporting the project. The applicant does no know of any other behavioral health provider who is in a position to accomplish this in existing space, without construction and without delay.

B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

The applicant is not proposing new construction.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as transfer agreements or contractual agreements for health services.

Crestwyn has a patient transfer agreement with both Baptist Hospital and St. Francis Hospital. It is co-owned by subsidiaries of Baptist and Saint Francis Hospitals. It has a sister hospital, Delta Medical Center, located across Shelby County to the west. Cretwyn contracts with all three MCO's in the area.

2. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

A. Positive Effects

Additional beds at Crestwyn will allow it to meet increasing demand for its inpatient services at almost no capital cost. The increased capacity will allow it to keep meeting the growing needs of Medicare, TennCare/Medicaid, indigent and self-pay patients who are almost 70% of the hospital's payor mix.

B. Negative Effects

Crestwyn does not believe that this small number of beds will have a significant adverse impact on other behavioral health providers in Shelby County, its primary service area. Between 2014 and 2016, JAR data indicate that patient days of psychiatric care provided by service area facilities increased from 211,255 to 226,916--a two-year increase of 15,661 patient days.

Crestwyn's 14 beds, even were they to be used to 100% capacity, would take only 5,110 patient days from the service area. That is only a third of the market growth that has occurred the past two years. So any impact the project may have on other providers is likely to be more than offset by short-term growth in community demand for this type of care.

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3.A Discuss the availability of an accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.

Crestwyn is an existing provider and is familiar with the requirements of Licensure and the Joint Commission. Crestwyn staffs its units in compliance with those and other professional standards.

This project will not require a large addition of staff; they can be recruited when needed.

B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

The applicant so verifies.

C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Crestwyn has a total of nine students from Baptist College of Health Sciences on campus at this time. Clinical rotation agreements are being discussed next year with the following other schools:

Southwest Tennessee Community College
The University of Memphis
Rhodes University
Union University
Christian Brothers University
Northwest Mississippi Community College--DeSoto Campus

4. Identify the type of licensure and certification requirements applicable and verify that the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Mental Health Hospital, from Tennessee Department of Mental Health and Substance Abuse Services (currently licensed and in good standing)

Certification Type: Medicare and TennCare/Medicaid Certification (current)

Accreditation: Joint Commission (current)

A. If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Crestwyn Behavioral Health is licensed in good standing, certified for both Medicare and Medicaid/TenCare, and accredited by the Joint Commission. Documentation is provided in the Attachments.

B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected, by providing a letter from the appropriate agency.

See Attachment Section B-Orderly Development-4B.

- C. Document and explain inspections within the past three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23- ore 90-day termination proceedings from Medicare or Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.
- (1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

- 5. Respond to all of the following and for such occurrences, identify, explain, and provide documentation:
- A. Has any of the following:
- (1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);
- (2) Any entity in which any person(s) or entity with more than 5% ownership (direct of indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or
- (3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%...
- B. Been subjected to any of the following:
- (1) Final Order or Judgment in a State licensure action;
- (2) Criminal fines in cases involving a Federal or State health care offense;
- (3) Civil monetary penalties in cases involving a Federal or State health care offense;
- (4) Administrative monetary penalties in cases involving a Federal or State health care offense;
- (5) Agreement to pay civil or monetary penalties to the Federal government or any State in cases involving claims related to the provision of health care items and services; and/or
- (6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs;
- (7) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware;
- (8) Is presently subject to a corporate integrity agreement.

6. Outstanding Projects:

- a. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and
- b. Provide a brief description of the current progress, and status of each applicable outstanding CON.

		Outstandi	ng Projects		
			Annual Prog	gress Report*	
CON Number	Project Name	Date Approved	Due Date	Date Filed	Expiration Date
CN					
Status:					
CN					
Status:				2.177.0570	

^{*} Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

- 7. Equipment Registry -- For the applicant and all entities in common ownership with the applicant.
- a. Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography Scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)?

No.

- b. If yes, have you submitted their <u>registration</u> to HSDA? If you have, what was the date of the submission?
- c. If yes, have you submitted their <u>utilization</u> to HSDA? If you have, what was the date of the submission?

	Date of HSDA	Date of Last
Facility	Registration	Utilization Submittal

QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency, concerning continued need and appropriate quality measures as determined by the Agency pertaining to the Certificate of Need, if approved.

The applicant so verifies.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

Both nationally and in the applicant's service area, there is a growing need for additional treatment resources for mental illness. Hospitals such as Crestwyn have an important role to play in the continuum of care for persons with treatment needs. Crestwyn's proposal for a small increase in bed complements, which will be of particular importance to its youth program, will help address this major health concern in the service area.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

Crestwyn is an active and significant provider in its service area. It now faces continuous bed shortages which limit its services to the community. This project will improve access to behavioral health care in the West Tennessee region.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

The project will provide needed bed capacity with great efficiency. Without the need for anything but furnishing patient bed spaces, the new beds can be added very quickly and at no significant cost.

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Crestwyn and Acadia Healthcare have strong quality improvement processes; and Crestwyn is both licensed and accredited.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

The project will require some new staff but not a large number of staff.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(3) states that "...Within ten (10) days of filing an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the member(s) of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

See Attachment "Proof of Publication".

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

- 1. Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
- 2. If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.

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PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Initial HSDA Decision Date	0	6-27-18
1. Architectural & engineering contract signed		
2. Construction documents approved by TDH		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete		
10. * Issuance of license		
11. *Initiation of service	60	8-27-18
12. Final architectural certification of payment	NA	NA
13. Final Project Report Form (HF0055)	120	10-27-18

^{*} For projects that $\underline{DO\ NOT}$ involve construction or renovation: please complete items 11-12 only.

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Carlotte Car

AFFIDAVIT

STATE OF	TENNESSEE_	
COUNTY OF	DAVIDSON	

JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, et seq., and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

SIGNATURE/TITLE CONSULTANT

Sworn to and subscribed before me this 14th day of March, 2018 a Notary

Public in and for the County/State of DAVIDSON

My commission expires

,2018 (Year) NOTARY PUBLIC

DANA

INDEX OF ATTACHMENTS

Section A

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Legal Status and Ownership Structure of Applicant

A-6A

Site Control Documentation

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Plot Plan

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Floor Plan

Section B

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Service Area Map

B-Economic Feasibility-2

Documentation of Funding/Financing Availability

B-Economic Feasibility-6A

Applicant's Financial Statements

B-Orderly Development-4B

Licensure and Accreditation Findings and Corrections

Other Attachments

Proof of Publication

Support Letters



July 1, 2016

Re: # 590562

CCN: Pending

Program: Psychiatric Hospital Accreditation Expiration Date: June 30, 2019

Michael J. Stokes CEO Crestwyn Health Group LLC 9485 Crestwyn Hills Memphis, Tennessee 38125

Dear Mr. Stokes:

This letter confirms that your June 27, 2016 - June 29, 2016 unannounced initial survey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals, as well as the special Conditions for psychiatric hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on July 01, 2016, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of July 01, 2016.

The Joint Commission is also recommending your organization for Medicare certification effective July 01, 2016. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is responsible for notifying the State Survey Agency that a recommendation for Medicare certification has been made. Please provide your State agency with a copy of your accreditation report, accreditation award letter, and this Medicare recommendation letter.

This recommendation applies to the following location(s):

Crestwyn Health Group d/b/a Crestwyn Behaviorai Health 9485 Crestwyn Hills, Memphis, TN, 38125

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark G. Pelletier, RN, MS Chief Operating Officer

Mark Pelletier

Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services CMS/Regional Office 4 /Survey and Certification Staff

are ledicalitical distribution of

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

July 1, 2016

Michael J. Stokes CEO Crestwyn Health Group LLC 9485 Crestwyn Hills Memphis, TN 38125

Joint Commission ID #: 590562 Program: Hospital Accreditation Accreditation Activity: 60-day Evidence of Standards Compliance Accreditation Activity Completed: 07/01/2016

Dear Mr. Stokes:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning June 30, 2016 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement,

Sincerely,

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

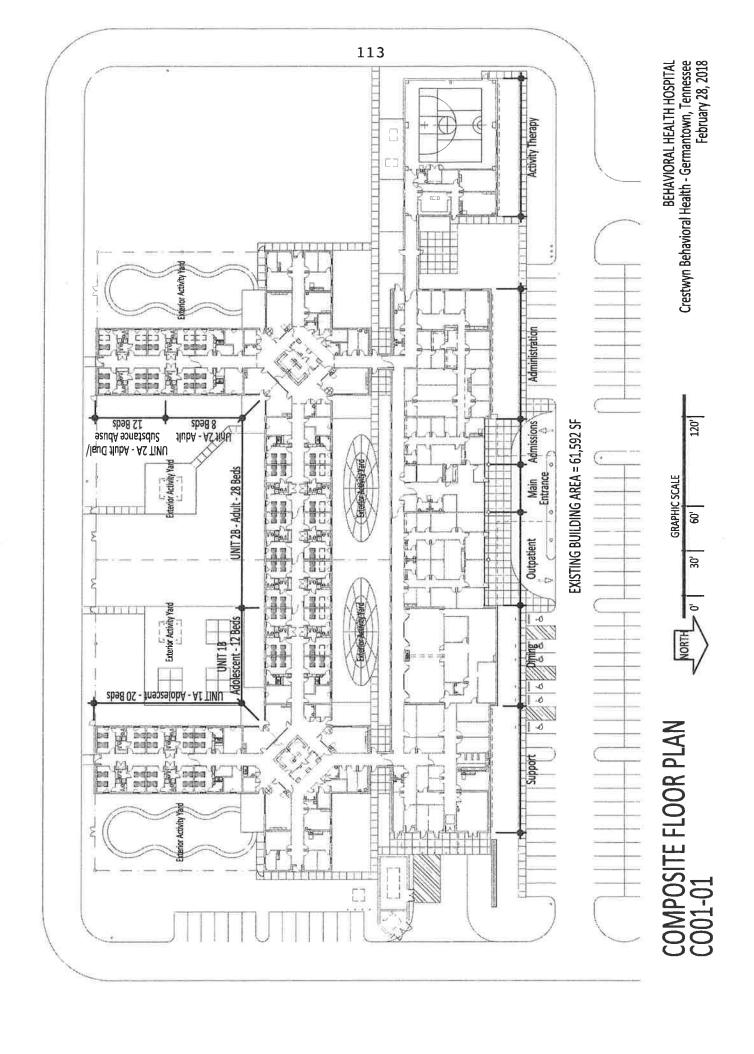
A-6B(1)a-d

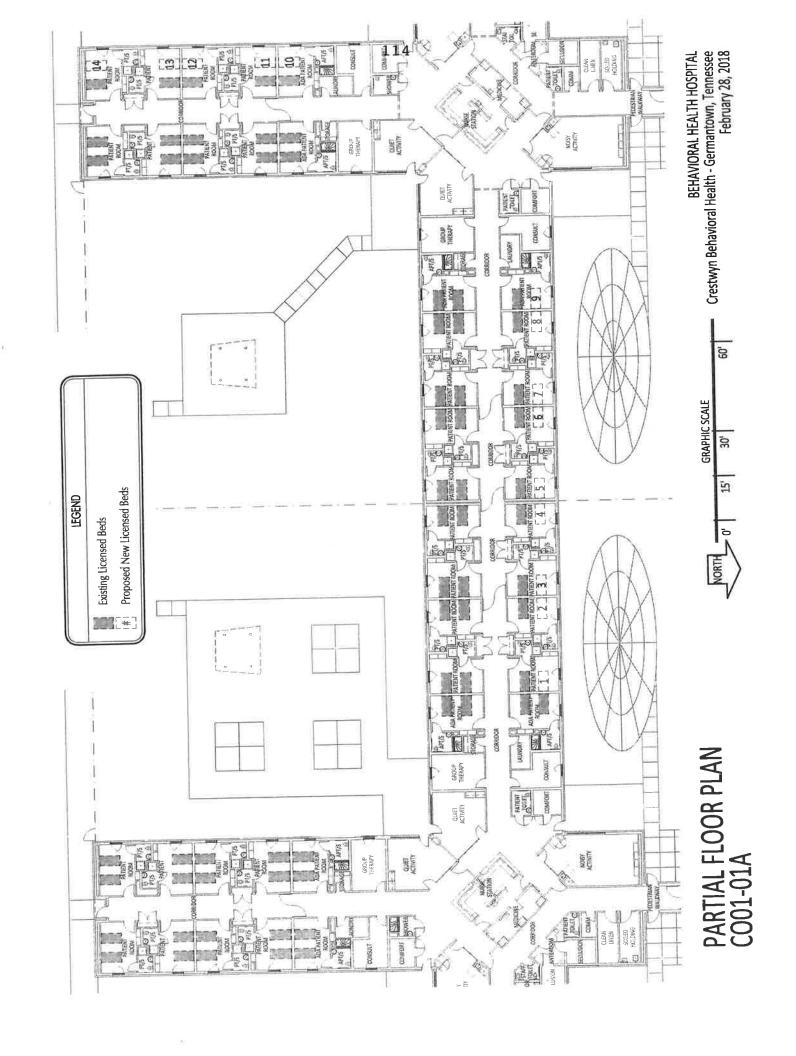
Plot Plan

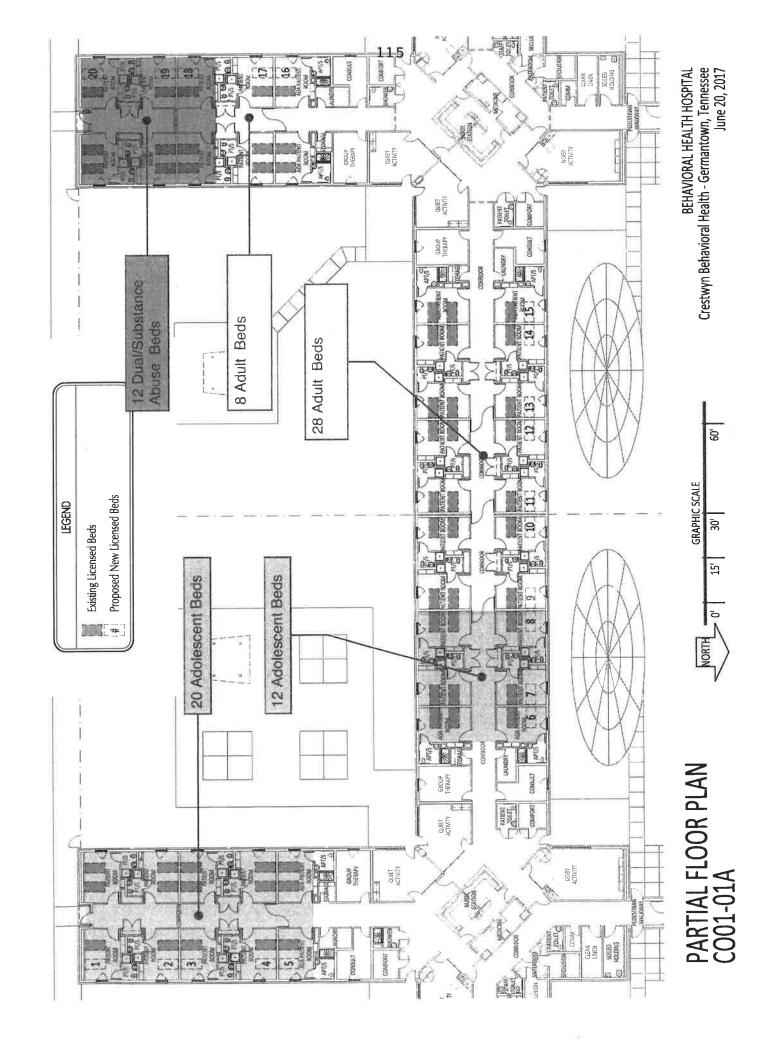
SITE PLAN CO01-00

A-6B(2)

Floor Plans

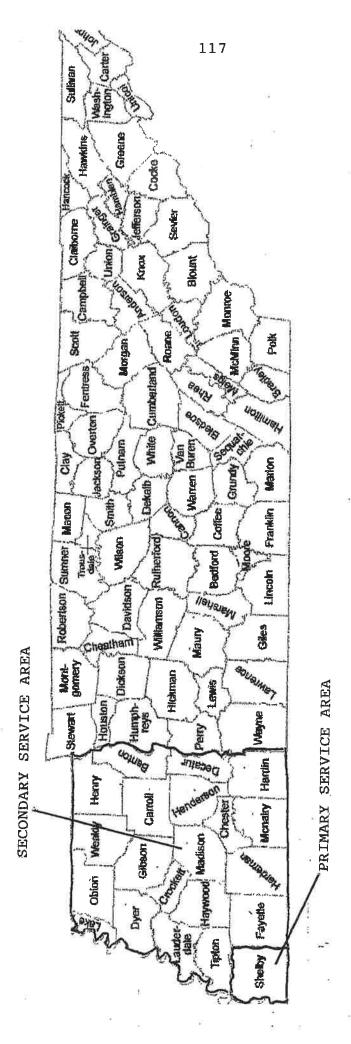






B-Need-3
Service Area Map

CRESTWYN BEHAVIORAL HEALTH



B-Economic Feasibility--2

Documentation of Funding/Financing Availability



March 15, 2018

Melanie M. Hill, Executive Director Tennessee Health Facilities Commission Andrew Jackson State Office Building, Suite 850 500 Deaderick Street Nashville, Tennessee 37243

Dear Mrs. Hill:

Crestwyn Behavioral Health is applying for a Certificate of Need to add and license 14 beds in existing patient rooms. This will require a capital expenditure of no more than approximately \$91,000.

As Chief Financial Officer, I am writing to confirm that Crestwyn will fund the project in cash. The application includes our financial statements documenting that sufficient cash reserves, operating income, and lines of credit exist to accomplish that.

Sincerely,

Stephen Lewis

Chief Financial Officer

B-Economic Feasibility-6A Applicant's Financial Statements

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ACADIA

Acadia Healthcare Crestwyn Consolidated Financial Summary Report December, 2017

	PY Var %		700 00	(%E 666)	R8 8%	(APK 6%)	(9/0,000)	40.0%	260.090	329.0%	(45.152)	%C:18		1,212.5%	%6 02	284.0%	(676.6%)	271.7%		1 (%4.64)	2 (%6'.68'52)		(1,713.0%)	(90.4%)	(68.3%)	(46.9%)	(56.2%)	(84.2%)	(26.8%)	57.8%	(169.0%)	(10)	(70.4%)	(107.3%)	189.6%			(54.1%)	(2.7%)	1 1000
	PY Var		17 415 000	(9.480.933)	1.354.387	(275,569)	(2000) (2)	O 087 818	4 265 600	0.00,000,	(504,514)	36,943	(8.474)	708.894	199,517	9,976,029	(726,017)	9,250,012		(2,759,007)	(83,518)	(590,334)	(160,943)	(265,295)	(821,684)	(139,995)	(82,041)	(47,603)	(25,223)	231,859	(65,369)	(108,996)	(756,850)	(5,674,998)	3,575,014			(292,169)	(24,288)	108,996
ate -	Bud Var %		10.3%	12.8%	64.5%	(356.7)%	24 00/	60.1%	/94 7/94	A(1.10)	21.0 %	102.9%	28.5%	25.9%	(2.8)%	54.2%	(234.0)%	48.9%		(17.8)%	19.3%	(20.3)%	2	(87.9)%	(85.9)%	(1.1)%	40.3%	%(8.69)	(43.9)%	in.	(30.1)%	Ð	(70.5)%	(43.4)%	98.8%			0.3%	17.0%	10 20
Year to Date	Bud Var		2.479.500	2,025,886	310,952	(257,801)	38 464	4.596.998	(752.550)	877 078	20,010	7.320	3.386	157,937	(13,876)	4,741,059	(583,790)	4,157,269		(992,352)	20,041	(185,155)	(170,338)	(261,328)	(1,033,176)	(4,870)	154,255	(42,831)	(19,464)	(1)	(24,053)	9	(758,212)	(3,317,483)	839,787			2,620	192,243	108,996
	Budget		24,090,000	15,772,413	481,800	72,272	120 448	7.643.067	2.372.000	1 719.881	03 720	7.116	11,860	609,423	494,668	8,747,158	249,527	8,497,631		4,588,405	103,864	910,184	٠	297,465	170,074	433,611	382,336	61,319	24,911	169,404	80,000	108,996	317,281	7,647,870	849,761	10.0%		834,615	1,129,000	1.063.645
	Actual		26,569,500	13,746,527	170,848	330,073	81.987	12,240,065	1.619.450	842.803	1.016	(204)	8,474	767,360	480,792	13,488,217	833,317	12,654,900		5,580,757	83,843	1,095,339	170,338	558,793	1,203,250	438,481	228,081	104,150	44,375	169,405	104,053	108,996	1,075,493	10,965,353	1,689,548	13.4%		831,995	936,757	1 659 757
		Revenues & Adjustments	93.1% IP Gross Revenue	1%) IP Contractual Deductions	0% IP Rev Deducts - Admin	(%) IP Rev Deducts - Charity	19. IP Rev Deducts - Denials	122.0%IP Net Revenue	9% OP Gross Revenue			OP Rev Deducts - Charity	OP Rev Deducts - Denials	292.7% OP Net Revenue	Non-Operating Revenue	Net	%) Bad Debt Expense	123.0%Net Revenue	Орег				%) Contract Labor	%) Purchase Svos	%) Professional Fees	% Supplies	%) Utilities		%) Rent/Lease Exp less Interco Rent	% Insurance Expense	2% Marketing Exp		2. Other Operating Expense	24.7%)Total Operating Expenses	86.1%EBITDA	EBITDA % of Net Revenue	Non-Operating Expenses	1% Depreciation and Amortization	% Intercompany Interest	72.3%Total Non Operating Expenses
	ar PY Var %		1,093,500 93.	(524,360) (82.8%)	14,553 56.0%	(14,153) (43.2%)	(1,444) (8.5%)	568,096 122.	46,675 38.9%	(7,538) (8.3%)	12,224 100.0%	6		51,362 292.	(34,621) (95,6%)			582,778 123.0		(97,503) (20.6%)			0)	(3,220) (7.5%)	_			_	_		10,963 81.2%		1		411,311 186.1			089 1.0%	3,956 4.5%	
	Bud Var % PY Var		19.7% 1,0			(725.6)% (1	(94.4)%	72.0% 5	(21.3)%	36.3%	100.0%	100.0%	103.0%	26.5%		4)		56.0% 58				(24.0)% (1			_				(42.4)%		61.4%		(31.0)%		304.6% 41			2.1%	13.5%	73.9% 11
Period	Bud Var Buc		373,500	82,748	26,445	(41,244)	(8.942)	432,508	(45,250)	55,875	2,120	636	1,060	14,441	(38,695)	407,253	(27,920)	379,333	1000 100	(069,16)	4,420	(17,629)	(37,674)	(23,464)	(020,09)	12,949	14,392	(3,160)	(1,523)	0	4,042	9	(10,537)	(236,086)	143,248			1,492	13,081 108,996	123,568
	Budget		1,894,500	1,240,385	37,890	5,684	8,472	601,069	212,000	153,716	2,120	989	1,060	54,468	41,306	696,843	19,623	677,220	900	900,000	8,657	73,439	0	22,799	13,464	34,121	31,139	5,151	2,072	14,117	6,584	9,083	23.483	630,197	47,023	6.9%		70,211	000'26	167,211
	Actual		2,268,000	1,157,637	11,445	46,928	18,414	1,033,577	166,750	97,841	***	¥		68,909	1,611	1,104,096	47.543	Sec, deu, l	072 040	40,010	4,237	91,068	37,674	46,263	103,534	21,172	16,747	LT8,8	080's	74,117	2,542	9,083	34,020	866,283	190,271	18.0%		68,719	83,919	43,643

1

ACADIA

Acadia Healthcare Crestwyn Consolidated Financial Summary Report December, 2017

	PY Var %	53 138.8%Pretax Income	-Provision for Income Taxes	53 138.8%.Net Income from Operations	53 138,8%Net income	53 138.8%Net Income Attributable to Acadia
	PY Var	524,953		524,953	524,953	524,853
<u>:</u>	Bud Var %	222.0%		222.0%	222.0%	222.0%
Periodic	Bud Var Bud Var %	266,816		266,816	266,816	266.816
	Budget	(120,188)		(120,188)	(120,188)	(120,188)
	Actual	146,628		146,628	146,628	146,628

Actual	Budget	Bud Ver	Bud Var %	PY Var	PY Var %
29,791	(1,113,854)	1,143,645	102.7%	3,367,554	100.9%
		•	×	278	100.0%
29,791	(1,113,854)	1,143,645	102.7%	3,367,832	100.9%
29,791	(1,113,854)	1,143,645	102.7%	3,367,832	100.9%
29,791	(1,113,854)	1,143,645	102.7%	3.367.832	100 9%

Acadia Healthcare Company, Inc. Consolidated Balance Sheets

Other current assets 107,537 66,895 Total current assets 427,927 294,736 Property and equipment: Land 411,331 214,138 Building and improvements 2,031,819 12,77,800 Equipment 318,020 141,543 Construction in progress 157,114 195,042 Less accumulated depreciation 2,703,695 1,709,053 Goodwill 2,681,188 2,128,215 Intangible assets, net 3,310 59,575 Deferred tax assets – noncurrent 3,780 49,114 Derivative instruments 73,509 -4279,208 Other assets 5,1317 38,515 Total assets 5 6,024,726 \$4,279,208 ** Total assets 11,317 38,515 Current liabilities 80,034 91,341 Accrued salaries and benefits 105,068 80,696 Other accrued liabilities 32,35,004 2,195,386 Total current liabilities 32,35,004 2,195,386			-	Decemi	oer 3	
Current assets: Cash and cash equivalents			(1	n thousands, exc		hare and per
Current assets: Cash and cash equivalents Cash and cash equivalents Accounts receivable, net of allowance for doubtful accounts of \$38,916 and \$29,332, respectively Other current assets 107,337 66,895 Total current assets 107,337 294,736 Property and equipment: 2,031,819 2,271,800 Equipment 318,000 141,543 Equipment 318,000 141,543 Construction in progress 157,114 195,042 Less accumulated depreciation 2,703,695 1,709,053 Coodwill 1,709,053 1,709,053 Coodwill 1,709,053 1,709,053 Coodwill 1,709,053 1,709,053 Total assets 1,709,053 1,709,053 Coodwill 1,709,053 1,709,053 Coodwill 1,709,053 1,709,053 Construction in progress 3,310 59,575 Deferred tax assets 1,709,053 1,709,053 Construction of long-term debt 3,38,00 4,114 Current portion of long-term debt 3,4805 5,4360 Accounts payable 3,253,004 2,195,384 Current debt 3,253,004 2,195,384 Deferred tax liabilities 105,068 30,596 Total current liabilities 105,068 3,253,004 Current liabilities 1,295 3,233,004 Current liabilities 1,295 3,233,004 Current liabilities 1,295 3,293,004 Current liabilities 1,295 3		ASSETS				
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Property and equipment:			-		-	294.736
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Accounts payable		Current liabilities:				
Accrued salaries and benefits Other accrued liabilities Total current liabilities Total current liabilities Total current liabilities Total current liabilities Total liabilities Redeemable noncontrolling interests Equity: Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively Additional paid-in capital Accumulated other comprehensive loss Retained earnings Total equity		Current portion of long-term debt	\$	34,805	\$	
Other accrued liabilities 122,958 72,806 Total current liabilities 342,865 290,203 Long-term debt 3,253,004 2,195,384 Deferred tax liabilities – noncurrent 78,520 23,936 Other liabilities 164,859 78,602 Total liabilities 3,839,248 2,588,125 Redeemable noncontrolling interests 17,754 8,055 Equity: Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 867 707 Additional paid-in capital Accumulated other comprehensive loss Retained earnings (549,570) (104,647 Total equity 2,167,724 1,683,028		Accounts payable		/		
Total current liabilities 342,865 290,203 ★ Long-term debt 3,253,004 2,195,384 Deferred tax liabilities – noncurrent 78,520 23,936 Other liabilities 164,859 78,602 Total liabilities 3,839,248 2,588,125 Redeemable noncontrolling interests 17,754 8,055 Equity: Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 86,688,199 and 70,745,746 issued 47,745,7		Accrued salaries and benefits				
Long-term debt 3,253,004 2,195,384 Deferred tax liabilities - noncurrent 78,520 23,936 Other liabilities 164,859 78,602 Total liabilities 3,839,248 2,588,125 Redeemable noncontrolling interests 17,754 8,055 Equity: Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 867 707 Additional paid-in capital 2,496,288 1,572,972 Accumulated other comprehensive loss (549,570) (104,647 Retained earnings 220,139 213,996 Total equity 2,167,724 1,683,028		Other accrued liabilities		122,958		72,806
Long-term debt		Total current liabilities	7	342,865		290,203
Deferred tax liabilities - noncurrent	*		>	3,253,004		2,195,384
Other liabilities 164,859 78,602 Total liabilities 3,839,248 2,588,125 Redeemable noncontrolling interests 17,754 8,055 Equity: Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued	47	Deferred tax liabilities - noncurrent		78,520		23,936
Total liabilities 3,839,248 2,588,125 Redeemable noncontrolling interests 17,754 8,055 Equity: Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 867 707 Additional paid-in capital 2,496,288 1,572,972 Accumulated other comprehensive loss Retained earnings (549,570) (104,647 Total equity						78,602
Redeemable noncontrolling interests 17,754 8,055 Equity: Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively 867 707 Additional paid-in capital 2,496,288 1,572,972 Accumulated other comprehensive loss Retained earnings (549,570) (104,647) Total equity				3.839.248		2.588.125
Equity: Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively Additional paid-in capital Accumulated other comprehensive loss Retained earnings Total equity Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued 867 707 2,496,288 1,572,972 (104,647 Retained earnings 220,139 213,996						, ,
Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively Additional paid-in capital Accumulated other comprehensive loss Retained earnings Total equity Preferred stock, \$0.01 par value; 10,000,000 shares authorized at December 31, 2016 and 2015, respectively 867 707 Additional paid-in capital 2,496,288 1,572,972 (104,647 Retained earnings 220,139 213,996				2.,,		94000
Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively Additional paid-in capital Accumulated other comprehensive loss Retained earnings Total equity Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively 867 707 4,496,288 1,572,972 (104,647 220,139 213,996 213,996		Preferred stock \$0.01 par value: 10.000,000 shares authorized no shares issued				
December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued and outstanding as of December 31, 2016 and 2015, respectively Additional paid-in capital Accumulated other comprehensive loss Retained earnings Total equity 2,496,288 2,496,288 1,572,972 (104,647 220,139 213,996 213,996		Common stock \$0.01 par value: 180,000,000 and 90,000,000 shares authorized at				
and outstanding as of December 31, 2016 and 2015, respectively Additional paid-in capital Accumulated other comprehensive loss Retained earnings Total equity And outstanding as of December 31, 2016 and 2015, respectively 2,496,288 1,572,972 (104,647) 220,139 213,996 213,996						
Additional paid-in capital 2,496,288 1,572,972 Accumulated other comprehensive loss (549,570) (104,647 Retained earnings 220,139 213,996 Total equity 2,167,724 1,683,028		and outstanding as of December 31, 2016 and 2015, respectively		867		707
Accumulated other comprehensive loss (549,570) (104,647 Retained earnings 220,139 213,996 Total equity				2.496.288		1.572.972
Retained earnings 220,139 213,996 Total equity 2,167,724 1,683,028						
Total equity 2,167,724 1,683,028						
		50.00 A 20.00	-		-	
Total habilities and equity $\frac{5}{2}$ $\frac{6,024,726}{2}$ $\frac{5}{2}$ $\frac{4,279,208}{2}$		* *	di.		a	
		Total habilities and equity	Þ	0,024,720	D	4,219,208

See accompanying notes.

Acadia Healthcare Company, Inc. Condensed Consolidating Balance Sheets December 31, 2015 (In thousands)

		Parent		Combined Subsidiary Guarantors	Combined Non- Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:						Q.	
Cash and cash equivalents		\$ -	-	\$ 1,987	\$ 9,228	\$ —	\$ 11,215
Accounts receivable, net		11.00		187,546	29,080	-	216,626
Other current assets		-		57,968	8,927		66,895
Total current assets		-		247,501	47,235		294,736
Property and equipment, net		-	+	805,439	903,614	-	1,709,053
Goodwill		= =		1,835,339	292,876		2,128,215
Intangible assets, net		_		57,024	2,551		59,575
Deferred tax assets - noncurrent		3,94	6	40,587	4,581	-	49,114
Investment in subsidiaries		3,495,06	7			(3,495,067)	-
Other assets		427,27		32,947	2,322	(424,024)	38,515
Total assets		\$3,926,28	3	\$3,018,837	\$1,253,179	\$(3,919,091)	\$4,279,208
Current liabilities:		1001	707-1	3		CHANGE OF THE SE	
Current portion of long-term debt	- 5	\$ 45,12	25	\$ —	\$ 235	\$ —	\$ 45,360
Accounts payable		a leagu		75,015	16,326	-	91,341
Accrued salaries and benefits		1944		66,249	14,447	200	80,696
Other accrued liabilities		26,13	12	10,886	35,788	April 1	72,806
Total current liabilities		71,25		152,150	66,796		290,203
Long-term debt		2,171,99			447,410	(424,024)	2,195,384
Deferred tax liabilities – noncurrent		-	_	-	23,936	-	23,936
Other liabilities		_	_	75,159	3,443	-991	78,602
Total liabilities		2,243,25	55	227,309	541,585	(424,024)	2,588,125
Redeemable noncontrolling interests				-	8,055		8,055
Complete By Golden Williams		1,683,02	28	2,791,528	703,539	(3,495,067)	1,683,028
Total equity					\$1,253,179	\$(3,919,091)	\$4,279,208
Total liabilities and equity		\$3,926,28	(A)	\$3,018,837	01,433,179	\$(3,717,071)	9-75#17 JEUO

Acadia Healthcare Company, Inc. Condensed Consolidating Balance Sheets December 31, 2016 (In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non- Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:					112.7
Cash and cash equivalents	\$ —	\$ 15,681	\$ 41,382	\$	\$ 57,063
Accounts receivable, net		209,124	54,203	-	263,327
Other current assets	-	61,724	45,813	((444)	107,537
Total current assets		286,529	141,398		427,927
Property and equipment, net		940,880	1,762,815		2,703,695
Goodwill		1,935,260	745,928	-	2,681,188
Intangible assets, net	N-mile	56,676	26,634	-	83,310
Deferred tax assets - noncurrent	13,522		4,606	(14,348)	3,780
Derivative instruments	73,509	-	,	_	73,509
Investment in subsidiaries	4,885,865		2	(4,885,865)	-
Other assets	493,294	40,480	7,189	(489,646)	51,317
Total assets	\$5,466,190	\$3,259,825	\$2,688,570	\$(5,389,859)	\$6,024,726
Current liabilities:					
Current portion of long-term debt	\$ 34,550	\$	\$ 255	\$	\$ 34,805
Accounts payable		49,205	30,829		80,034
Accrued salaries and benefits	-	72,835	32,233		105,068
Other accrued liabilities	33,616	24,375	64,967		122,958
Total current liabilities	68,166	146,415	128,284	_	342,865
Long-term debt	3,230,300	,500 -	512,350	(489,646)	3,253,004
Deferred tax liabilities - noncurrent		40,574	52,294	(14,348)	78,520
Other liabilities		101,938	62,921		164,859
Total liabilities	3,298,466	288,927	755,849	(503,994)	3,839,248
Redeemable noncontrolling interests	-		17,754	_	17,754
Total equity	2,167,724	2,970,898	1,914,967	(4,885,865)	2,167,724
Total liabilities and equity	\$5,466,190		\$2,688,570	\$(5,389,859)	\$6,024,726

B-Orderly Development-4B

TDOH and Joint Commission Findings and Corrections



Official Accreditation Report

Crestwyn Health Group LLC 9485 Crestwyn Hills Memphis, TN 38125

Organization Identification Number: 590562

Initial Unannounced Full Event: 6/27/2016 - 6/29/2016

Report Contents

Executive Summary

Survey Analysis for Evaluating Risk (SAFER™)

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right.

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. (Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Executive Summary

Program(s)
Hospital Accreditation

Survey Date(s) 06/27/2016-06/29/2016

Hospital Accreditation:

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

• Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission \$AFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

All Evidence of Standards Compliance (ESC) forms, which outline corrective actions, will be due in 60 days. For those findings of a higher risk, two additional fields will be required within the ESC for the organization to provide a more detailed description of leadership involvement and preventive analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER Matrix Placement	Required Follow-Up Activity
LOW/LIMITED	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
MODERATE/PATTERN, MODERATE/WIDESPREAD	 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey
HIGH/LIMITED, HIGH/PATTERN,	 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate that ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.

Organization Identification Number: 590562

The Joint Commission 131 SAFER Matrix

Hospital Accreditation Program

			Treophal Addicates Training	
y -	High	PC.01.02.09 EP 7		
Patient/Visitor/Staff	·			
Ĭ		WT.05.01.01 EP 3	EC.02,04.03 EP 1	PC.01.02.13 EP 2
ıţie			PC.01.02.13 EP 6	PC.01.03.01 EP 1
Likelihood to Harm a Pa	Moderate		RC.02.04,01 EP 3	
K e		LS.02.01.20 EP 26	MS.06.01.05 EP 7	
		MM.04.01.01 EP 9	PC.01.03.01 EP 5	
	Low	PC.01.02.01 EP 23	RC.02.03.07 EP 4	
		Limited	Pattern	Widespread
			Scope	•
	15		Scohe	

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. (Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

The Joint Commission 133 Summary of CMS Findings

CoP:

§482.24

Tag: A-0431

Deficiency: Standard

Corresponds to: HAP

Text:

§482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual

evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(2)	A-0450	HAP - RC.02.03.07/EP4	Standard

CoP:

§482.41

Tag: A-0700

Deficiency: Standard

Corresponds to: HAP

Text:

§482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP1	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP26	Standard

CoP:

§482.61

Tag: B103

Deficiency: Standard

Corresponds to: HAP

Text:

§482.61 Condition of Participation: Special medical record requirements for psychiatric

hospitals.

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

CoP Standard	Tag	Corresponds to	Deficiency
§482.61(e)	B133	HAP - RC.02.04.01/EP3	Standard
§482.61(a)(5)	B109	HAP - PC.01.02.13/EP6	Standard
§482.61(b)(7)	B117	HAP - PC.01.02.13/EP2	Standard
§482.61(c)(1)	B119	HAP - PC.01.03.01/EP1	Standard
§482.61(c)(1)(ii)	B121	HAP - PC.01.03.01/EP5	Standard

CoP:

§482.22

Tag: A-0338

Deficiency: Standard

Corresponds to: HAP

Text:

§482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

The Joint Commission $^{134}_{134}$ Summary of CMS Findings

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.06.01.05/EP7	Standard

Requirements for Improvement - Detail

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.04.03

Standard Text:

The hospital inspects, tests, and maintains medical equipment.

Element(s) of Performance:

1. For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

For hospitals that use Joint Commission accreditation for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

EP 1

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

During the document review and staff interview it was observed that the hospital did not perform safety, operational and functional checks before initial use for all of the hospital's medical equipment listed on the medical equipment inventory list. It was observed that the hospital started receiving their patients on May 2, 2016 and the documentation verified that the initial inspections of the medical equipment which includes but not limited to 3 AED devices were not conducted until June 2, 2016.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.20

Standard Text:

The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

26. In new buildings, no dead-end corridor is longer than 30 feet. (For full text and any exceptions, refer to NFPA 101-2000: 18.2.5.10)

Note: Existing dead-end corridors are permitted to be used if it is impractical and unfeasible to alter them. (For full text and any exceptions, refer to NFPA 101-2000: 19.2.5.10)

Likelihood to Cause Harm:

Low

Scope:

Limited

Observation(s):

EP 26

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

During the building tour it was observed that the corridor near the dietary department and hazardous area room 1154 had a dead end corridor that was greater than 30 feet.

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.06.01.05

Standard Text:

The decision to grant or deny a privilege(s), and/or to renew an existing privilege

(s), is an objective, evidence-based process.

Element(s) of Performance:

7. The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

Likelihood to Cause Harm:

Low

Scope:

Pattern

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EP 7

§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.

This Standard is NOT MET as evidenced by:

Observed in Credentialing and Privileging at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service. In 2 of 3 medical staff/credentialing files reviewed, Radiologist chart's had the NPDB queried in 2014, but not before starting work for the hospital in May 2016

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.04.01.01

Standard Text:

Medication orders are clear and accurate.

Element(s) of Performance:

A diagnosis, condition, or indication for use exists for each medication ordered.

Note: This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.

Likelihood to Cause Harm:

Low

Scope:

Limited

Observation(s):

EP9

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. One record had multiple medications that did not have indications. The medications were Depakote and Geodon. The MD note did not explain the use of the medications.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.01

Standard Text:

The hospital assesses and reassesses its patients.

Element(s) of Performance:

23. During patient assessments and reassessments, the hospital gathers the data and information it requires. (See also PC.01.01.01, EP 24)

Likelihood to Cause Harm:

Low

Scope:

Limited

Observation(s):

EP 23

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. One patient who scored low fall risk was not rescreened in one week according to directions on the form. However, the policy for fall risk does not address reassessments.

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. While the CAGE assessment had been done, the actual alcohol assessment had not been done. The patient was admitted 6/21/16 and the assessment should be done within 72 hours according to hospital policy.

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 10 patient records reviewed, of both open and closed medical records the section of the medical history and physical exam that addressed previous surgical procedures was left blank. It is likely that the patient, an adolescent, had not had any procedures in the past, however, that should have been indicated in the medical history and physical examination.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.09

Standard Text:

The hospital assesses the patient who may be a victim of possible abuse and

neglect.

Element(s) of Performance:

7. The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. (See also RI.01.06.03, EP 3)

Likelihood to Cause Harm:

High

Scope:

Limited

Observation(s):

EP 7

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 1 patient records reviewed, closed medical record of a 17 year old adolescent who had been admitted for severe depression and melancholy in part related to her first sexual encounter which she related to care givers upon admission. The encounter had occurred, ostensibly, with a 25 year old man. There was no discussion in the medical record that the sexual molestation had been reported to the Division of Child Protective Services.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.13

Standard Text:

The hospital assesses the needs of patients who receive treatment for emotional

and behavioral disorders.

Element(s) of Performance:

2. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:

- Current mental, emotional, and behavioral functioning
- Maladaptive or other behaviors that create a risk to the patient or others
- Mental status examination
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient's care
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient's illness and circumstances leading to admission
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan (See also PC.01.03.01, EP 1)

Likelihood to Cause Harm:

Moderate

Scope:

WideSpread

- 6. Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:
- A psychiatric evaluation
- Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.01.02.03, EP 4)

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

EP 2

§482.61(b)(7) - (B117) - (7) Include an inventory of the patient's assets in descriptive, not interpretative, fashion. This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 9 of 10 patient records reviewed, Both open and closed medical records reviewed the inventory of assets checked in the psychiatric evaluation did not give sufficient detail to determine how they should be used in treatment of the patient. The recreation therapist did detail activity preferences including games, television programs, sports in the activities interventions of the plan. However, these don't demonstrate the personal strengths as defined in the interpretive guidelines of conditions of participation: "...although the term strength is often used interchangeably with assets, only the assets which describe personal strengths on which to base the treatment plan or which are useful in therapy represent personal strengths. Strengths are personal attributes i.e. knowledge, skills, aptitudes, personal experiences, education, talents and employment status which may be useful in developing a meaningful treatment plan..."

EP 6

§482.61(a)(5) - (B109) - (5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 1 of 10 patient records reviewed, One of the 10 open and closed medical records reviewed had an incomplete neurological exam. The cranial nerve evaluation was not completed.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.03.01

Standard Text:

The hospital plans the patient's care.

Element(s) of Performance:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2; PC.01.02.13, EP 2)

Likelihood to Cause Harm:

Moderate

Scope:

WideSpread

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.

Likelihood to Cause Harm:

Low

Scope:

Pattern

Observation(s):

FP 1

§482.61(c)(1) - (B119) - (1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities.

The written plan must include-

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 9 of 10 patient records reviewed, Both open and closed it was evident that the treatment plan was not based on the inventory of the patient's strengths and disabilities. The selection of strengths and disabilities that is attached to the Master Treatment Plan is a check list and not further referenced in the goals established in the treatment plan. It also does not correlate with the inventory of strengths and disabilities of the checklist in the psychiatric evaluation. General statements such as "hobbies", "motivation", "talents" etc. should be followed with further detail of what each of those selections reference. Of note; the activities therapists do lists "likes" and "dislikes" in the treatment plans that include specific sports, activities, television etc.

EP 5

§482.61(c)(1)(ii) - (B121) - (ii) Short-term and long-range goals;

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 3 of 6 patient records reviewed, There were goals that were not measurable. Examples include: "David will process life stressors contributing to depression." and "Pt will have alternative coping strategies that reinforce positive outcomes." "will be compliant with detox protocol."

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.02.03.07

Standard Text:

Qualified staff receive and record verbal orders.

Element(s) of Performance:

4. Verbal orders are authenticated within the time frame specified by law and regulation.

by law and rogalatio

Likelihood to Cause Harm:

Low

Scope:

Pattern

Observation(s):

EP 4

§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 2 of 7 patient records reviewed, Verbal orders had not been signed within the 48 hours which was the hospital's policy. One telephone order contained 5 different medications and was given on 5/11/16 and was signed on 5/14/16. Another medication had been given on 6/23/15 and had not been signed by 6/27/16 during the survey.

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.02.04.01

Standard Text:

The hospital documents the patient's discharge information.

Element(s) of Performance:

- 3. In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:
- The reason for hospitalization
- The procedures performed
- The care, treatment, and services provided
- The patient's condition and disposition at discharge
- Information provided to the patient and family
- Provisions for follow-up care

Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

EP 3

§482.61(e) - (B133) - §482.61(e) Standard: Discharge planning and discharge summary.

The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

in 3 of 3 patient records reviewed, All closed medical records that had a discharge summary and "Discharge Plan" there was a recapitulation of the patient's hospital course, however, none of the three contained a detail of the goals and specifically goal attainment.

Chapter:

Waived Testing

Program:

Hospital Accreditation

Standard:

WT.05.01.01

Standard Text:

The hospital maintains records for waived testing.

Element(s) of Performance:

3. Quantitative test result reports in the medical record for waived testing are accompanied by reference intervals (normal values) specific to the test method used and the population served. Note 1: Semiquantitative results, such as urine macroscopic and urine dipsticks, are not required to comply with this element of performance.

Note 2: If the reference intervals (normal values) are not documented on the same page as and adjacent to the waived test result, they must be located elsewhere within the permanent medical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the medical record.

Likelihood to Cause Harm:

Moderate

Scope:

Limited

Observation(s):

EP3

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 1 patient records reviewed, Closed medical record of a very brittle diabetic patient it was noted that the reference ranges for the device used for point of care testing for blood glucose was not in the patient's medical record.

The Joint Commission 145

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs:

0

Proof of Publication

Support Letters



Date: March 12, 2018

Melanie Hill Executive Director Tennessee Health Services & Development Agency Frost building, 3rd Floor 161 Rosa Park Blvd. Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Alliance Healthcare Services, I want to express our strong support for the certificate of need application referenced above.

Alliance Healthcare Services is the largest provider of outpatient mental health care in Shelby County. We serve individuals and families of all ages. We accept TennCare, Medicare, Safety Net, some private insurance and have a sliding scale fee. Our services include outpatient medicine management; individual, group, and family therapy; care coordination; peer support; a continuum of housing services; and a continuum of crisis services. In addition, we provide services for many specialty grants and are adding primary care.

Alliance Healthcare Services would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely.

Gene Lawrence, CEO

(901)369-1420 (901)567-3558

glawrence@alliance-hs.org



March 9, 2018:

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Youth Villages Specialized Crisis Services, I want to express our strong support for the certificate of need application referenced above.

The Youth Villages Specialized Crisis Services staff provides assessment and evaluation of children and youth, up to age 18, who are experiencing a psychiatric emergency across the state of Tennessee.

Youth Villages would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Brittany Farrar

Director - Youth Villages Specialized Crisis Services

615-250-7322

Brittany.farrar@youthvillages.org

3310 Perimeter Hill Drive, Nashville, TN 37211 | office 615.250.7200 |

www.youthvillages.org



February 16, 2018

Melanie Hill, Executive Director Tennessee Health Services & Development Agency Frost building, 3rd Floor 161 Rosa Park Blvd. Nashville, TN 37243

RE: Crestwyn Behavioral Health Certificate of Need Application

Dear Ms, Hill:

On behalf of NAMI Memphis I want to express our strong support for the certificate of need application referenced above.

NAMI Memphis is a non-profit, self-help organization offering support, education and information to individuals living with mental illness as well as their family and friends. Since 1984 the mission of NAMI Memphis has been to improve the quality of life for persons with severe and persistent mental illnesses and for their families/caregivers, metal health providers, police officers, and the general public through education, support, and advocacy. NAMI provides classes and support groups to mentally ill individuals; their families, friends, and caregivers; and advocacy in areas such as housing, insurance coverage, and health services. At the state and federal levels, NAMI advocates for fair and nondiscriminatory laws, and works to eliminate the stigma surrounding mental illness and brain disorders.

NAMI Memphis would like to express its support for Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016 Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout Memphis and Shelby County. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Memphis and Shelby County but for surrounding communities as well.

Sincerely,

Debra S. Dillon, MA, RN-BC Chief Executive Officer

> 5830 Mt. Moriah - Suite 6; Memphis, TN 38115 Phone 901.725.0305 - Fax 901.725.0306



PROFESSIONAL CARE SERVICES

of West TN, Inc.

REPLY TO:

[X] COVINGTON OFFICE: 1997 Highway 51 South Covington, TN 38019 (901) 476-8967 p (901) 476-2498 f

RIPLEY OFFICE:

403 Commerce Street Ripley, TN 38063 (731) 635-3968 p (731) 635-4215 f

|| SOMERVILLE OFFICE:

12615 South Main Somerville, TN 38068 (901) 465-9831 p (901) 465-8070 f

DYERSBURG OFFICE:

2380 Henry Street Dyersburg, TN 38024 (731) 287-1794 p (731) 287-1795 f

BROWNSVILLE OFFICE:

130 West Main Street Brownsville, TN 38012 (731) 772-9002 p (731) 772-9767 f

[] MILLINGTON OFFICE: 5281 Navy Road

5281 Navy Road Millington, TN 38053 (901) 873-0305 p (901) 873-0306 f February 16, 2018

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Professional Care Services, I want to express our strong support for the certificate of need application referenced above.

Professional Care Services of West Tennessee, Inc. is an agency composed of caring and involved professionals who are trained to respond to the mental health needs of their community through assessment, intervention, treatment, rehabilitation and support. Since the beginning, the primary purpose of our agency has been to provide services for the citizens of our communities. Through our six locations, PCS offers a broad range of traditional out-patient mental health services to adults and children. Clinical services may include mental health assessment, individual and group counseling/therapy, family therapy, psychiatric evaluations and medication management. Services are provided by medical doctors, Nurse Practitioners, master's level therapists, Certified Prevention Specialists, and Care Coordinators.

I would like to express support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Jimmie Jackson

CEO

(901) 622-1630

jimmie.jackson@peswtn.org

HELPING HANDS IN OUR COMMUNITY



February 13, 2018

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Quinco Mental Health Center (MHC), I want to express our strong support for the certificate of need application referenced above.

Quinco MHC is a community mental health center in West Tennessee. We provide mental health and substance abuse services in seven countles (Hardeman, McNairy, Hardin, Decatur, Chester, Madison and Henderson). Quinco provides outpatient therapy, medication services, care/case management, and crisis services. Quinco Mental Health Center has placed patients at Crestwyn through both our outpatient and crisis programs.

Quinco Mental Health Center would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city and all of West Tennessee. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Marlin Medlin Executive Director (731)658-6113

(731)658-6165

Marlin.Medlin@quincomhc.org

in Medlini



To Whom It May Concern,

First Step Recovery Centers would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Ashley Patrick, BSW

Clinical Director

901-522-1002

901-522 1004 fax

apatrick@firststeprecovery.org



Mark White

State Representative 83rd Legislative District

217 War Memorial Building Nashville, TN 37243

(615) 741-4415 Toll Free: 1-800-449-8368 ext. 44513

Rep.Mark.White@capitol.tn.gov

House of Representatives State of Tennessee

NASHVILLE

District Office: P.O. Box 17409 Memphis, TN 38187-0409

COMMITTEES:

Fiscal Review Chairman

House Rules Committee

Education Administration & Planning Chairman - Sub Committee

Consumer and Human Resources

2-21-18
Melanle Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

I would like to express my support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Mark White



Germantown Police Department

1930 South Germantown Road Germantown, Tennessee 38138 Police Administration Phone—901-757-7300 Police Administration Fax—901-751-7656

February 14, 2018

Melanie Hill, Executive Director Tennessee Health Services & Development Agency Frost Building, 3rd Floor 161 Rosa Park Boulevard Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the Germantown Police Department, I would like to express our strong support for the Certificate of Need application for Crestwyn Behavioral Health in Germantown, Tennessee.

The Germantown Police Department is a professional, progressive law enforcement organization committed to serving Germantown residents and visitors. With 99 officers and 21 public safety dispatchers, the Department is supported by civilian administrative staff and benefits from outstanding community support and civic involvement.

Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of mental health and substance abuse programs throughout the City of Germantown. Its close proximity to our Department has allowed us to make frequent use of their facility and services for our citizens. Having additional beds at Crestwyn would be an invaluable resource for not only the City of Germantown, but the surrounding municipalities as well.

Sincerely,

Richard L. Hall Chief of Police

Germantown Police Department

Date: 02/26/2018

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

Re: Crestwyn Behavioral Health Certificate of Need

Dear Ms. Hill:

On behalf of the staff of Bellevue Baptist Church Counseling Ministry, I want to express our strong support for the certificate of need application referenced above.

Bellevue Baptist Church provides "free" Biblical Counseling to both Bellevue members and non-Bellevue members. Thus; we make many referrals for Psychiatric in-patient care and I.O.P. services.

Bellevue Baptist Church would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Name: Dr. Mark Bowman

Title: Pastor of Biblical Counseling at Bellevue Baptist Church

Phone Number: 901-347-5830

Fax: 901-347-5846

Email: markbowman@bellevue.org



February 21, 2018

To Whom It May Concern:

As the Chief Executive Officer of Revelation of Hope Counseling Services, I would like to express support of Crestwyn Behavioral Health's request for expansion of additional bed space at its facility. Since opening its door in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout West Tennessee. I have received tremendous positive feedback from individuals who have received services at Crestwyn and I am continually making referrals to Crestwyn for treatment. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community throughout West Tennessee.

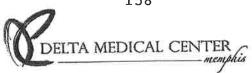
Sincerely,

Alvin Bonds II, NCC, ACS, RPT-S, LMFT, LPC/MHSP

Union D. Bonds II

National Certified Counselor
Approved Clinical Supervisor
Registered Play Therapist — Supervisor
Licensed Marital & Family Therapist

Licensed Professional Counselor/Mental Health Service Provider



March 6, 2018

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Delta Medical Center, I want to express our strong support for the certificate of need application referenced above. Delta Medical Center offers inpatient and outpatient hospital care in the greater Memphis, Tennessee area. We dedicate ourselves to being a center for excellence in providing behavioral health medicine, acute medical care, and a 7am-7pm emergency department.

Delta Medical Center would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Phil Willcoxon

Chief Executive Officer

(O) 901-369-8501

(F) 901-369-8503

phil.willcoxon@deltamedcenter.com

Supplemental #1 (Copy)

Crestwyn Behavioral Health

CN1803-018

March 26, 2018

Phillip M. Earhart, HSD Examiner Tennessee Health Services and Development Agency Andrew Jackson Building, 9th Floor 502 Deaderick Street Nashville, TN 37243

RE: CON Application CN1803-018 Crestwyn Behavioral Health

Dear Mr. Earhart:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. Section A, Executive Summary, Item 8 (Staffing), Page 4

a. It is noted the project will require approximately 2 nurses, 2 mental health techs, and a therapist. However, the staffing table on page 62 shows additional 3.80 techs, 1.40 nurses, and .76 recreational therapist as a result of the proposed project. Please clarify.

The applicant is amending the staffing information on page 4 and in Table Need-12 on page 62 of the application. Attached after this page are the revised pages 4R and 62R.

As reflected in the amended pages, the project will require 8.80 FTE's of additional staff. Of these, there will be 8.13 FTE's of direct patient care positions, consisting of 4.20 FTE's of mental health technicians, 2.53 FTEs of nurses, and 1.40 FTEs of Master's prepared clinicians. The original staffing chart listing a "recreational therapist" classification was inaccurate.

b. In addition, please clarify why the applicant is not hiring additional master's level or licensed therapist to provide individual and/or group therapy to the additional 14 patients if approved.

As indicated in response 1a above, additional Master's level staff is projected.

Page Two March 26, 2018

2. Section A, Project Details, Item 4.B (Type of Ownership), Page 8

a. It is noted on page 8 the applicant is 40% owned by Acadia Healthcare, Inc. However, the organizational chart in the attachments indicates Acadia owns 60%. Please clarify.

This was a typographical error. Acadia owns 60%. Attached following this page is a corrected page 8R.

b. Does Acadia own other health care institutions in Tennessee? If yes, please provide the name, current address, current status of Licensure/certification, and percentage of ownership for each health care institution identified.

Acadia owns all or part of three Tennessee hospitals and is developing a fourth in partnership with Erlanger Health Systems in Chattanooga.

		Status; Licensure	Percentage of
Name	Address	and Certification	Ownership
		Operational; licensed	
		and certified for	
		Medicare and	
	-	Medicaid; Joint	Acadia 60%
Crestwyn Behavioral	9485 Crestwyn Cove,	Commission	Baptist 20%
Health	Memphis, TN 38125	accredited	St. Francis 20%
		Operational; licensed	
		and certified for	
		Medicare and	
		Medicaid; Joint	
Delta Medical	3000 Getwell Road,	Commission	
Center	Memphis TN 38118	accredited	Acadia 100%
		Operational; licensed	
	17	and certified for	
		Medicare and	
	1000 371	Medicaid; Joint	
	1009 North	Commission	
	Thompson Lane,	accredited; Adding 36	
75	Murfreesboro, TN	beds under CN 1502-	4 1 1000/
Trustpoint Hospital	37129	006.	Acadia 100%
	Corner of North		
Palaman Dahari 1	Holtzclaw and Citico	ON11602-010	
Erlanger Behavioral	Avenues,	CN1603-012	Acadia%
Health	Chattanooga, TN	Under Development	Erlanger %

Page Three March 26, 2018

3. Section A, Project Details, Item 6A. (Legal Interest in the site), Page 9

Please provide a copy of the deed.

A copy of the deed is attached after this page.

4. Section A, Project Details, Item 9 (Medicaid/TennCare Medicare Participation) Page 13

It is noted the applicant does not have a TennCare Select contract. Please indicate if the applicant plans to contract with TennCare Select sometime in the future.

The applicant is contracted to TennCare Select through its contract with Blue Cross, which manages Select. Attached is a revise page 13R with the Select Box checked.

5. Section A. Applicant Profile, Item I, 6B (2) Floor Plan, Page 10

The floor plan is noted. However, please clarify how adults and children/adolescents will be segregated if this proposed project is approved.

The adult and child/adolescent patients occupy separate bed units. There are four program units now and there will be four when the project is implemented. They are separated by secured, steel double doors with privacy windows, and each unit is separately staffed and managed. In addition, children do not room with adolescents, the exception being a 10-12 year old patient and an adolescent no more than two years older--and then only with the approval of family and medical staff.

6. Section A., Bed Complement Data, Item 10.C, Page 14

a. It is noted the applicant has improvised the HSDA application to categorize the adult and geriatric together. Please revise the chart separating the two categories and submit a replacement page 14.

Page Four March 26, 2018

Crestwyn does not assign beds separately to geriatric adults and adults under the age of 65. They are treated in separate program groups as appropriate, but are not segregated by bed unit. A revised page 14R is submitted in response to question 6b below, but the applicant respectfully declines to show a separation that does not exist operationally.

b. On line 11, the applicant added a dual diagnosis category to the adult chemical dependency category. If a patient has a primary diagnosis of mental illness, those beds would be categorized as psychiatric. Please only include adult chemical dependency beds in line 11. Please revise and include changes in replacement page 14.

Attached after this page is a replacement page 14R, with the "dual diagnosis" words removed from line 11. Patients with substance abuse diagnoses are assigned to those beds.

c. Please provide a brief description of CN1606-024A and CN1603-012A.

CN1603-012: Granted to Erlanger Behavioral Health, a joint venture of Acadia and the Erlanger Health Sytem. Establishment of a new 88-bed inpatient psychiatric hospital in Hamilton County, to include inpatient, outpatient, and substance abuse services. Twelve of the approved beds would be transfers of geropsychiatric beds from Erlanger North.

<u>CN1606-024</u>: Granted to Trustpoint Hospital, LLC to add 88 hospitals beds to its psychiatric and rehabilitation bed complements in Rutherford County. The approved additional beds are 14 Children's psychiatric beds, 14 adolescent psychiatric beds, 52 adult psychiatric beds, and 8 physical rehabilitation beds.

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7. Section B, Need, Item I.a. (Psychiatric Inpatient Services-Service Specific Criteria-)

Please complete the following tables to determine psychiatric bed need (1).

The applicant has expanded and completed the requested tables and added a table inventorying bed complements by age and type of unit; please see the following pages.

	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need		
	Child/Adolescent 0-17	Child/Adolescent 0-17	Child/Adolescent 0-17	Child/Adolescent 0-17		
Proposed Primary						
Service Area	252,312	76	140	-64		
Proposed						
Secondary Service						
Area	148,338	45	0	45		
Total						
	400,650	120	140	-20		

	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Adults 18-64	Adults 18-64	Adults 18-64	Adults 18-64
Proposed Primary Service Area	593,476	178	N.A.	N.A.
Proposed Secondary Service Area	394,720	118	N.A.	N.A.
Total	988,196	296	See Below	See Below

	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Geriatric 65+	Geriatric 65+	Geriatric 65+	Geriatric 65+
Proposed Primary Service Area	135,234	41	N.A.	N.A.
Proposed Secondary Service				
Area	136,954	41	N.A.	N.A.
Total	-			
	272,188	82	See Next Page	See Next Page

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	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Adult & Geri 18+	Adult & Geri 18	Adult & Geri 18	Adult & Geri 18
Proposed Primary Service Area	728,710	219	604	-385
Proposed Secondary Service				
Area	531,674	160	278	-118
Total				
	1,260,384	378	882	-504

Crestwyn's application, as directed by the State Health Plan review criteria, projected bed need based on total licensed inpatient behavioral beds for all patients, not by three age cohorts. This is because there is insufficient information in the Joint Annual Report to permit utilization analysis and projection by all three age cohorts, as this question seeks to do. To quote Standard 1 in the State Health Plan (found on application page 19):

...the applicable JAR form does not provide occupancy rates by age category. Health Planning believes developing determination of need formulas specific to each age category is not possible at this time due to these limitations in available data.

Specifically, separate licensed bed assignments are not required for adult and geriatric adults; adult age mix changes according to the needs of the market, for many providers. To try to provide some information to the reviewer, the applicant has added a fourth table (above on this page) combining beds of the two adult cohorts.

In addition, on the following page the applicant provides a new table showing the service area's <u>staffed</u> behavioral bed complements by age cohort and by use (psychiatric or substance abuse), with a comparison to the licensed bed complements of the facilities. Bed staffing was derived from page 38 of the 2016 Joint Annual Reports of area providers.

W	arch	27,	2018
			March 27, g1 1:42 am

_	_			_	_		_	_		1	66	_	-	_	_		_		_	9.0
	Licensed	Licensed Beds Unvailable for IP		8	56	0	0	40	30	134			S	37	0	7	0	0	49	£1.1
	Lice	Total Licensed		345	111	114	34	80	09	744			12	187	22	25	16	16	278	1022
	ed	Total Staffed		337	55	114	34	40	30	610			7	150	22	18	16	16	229	839
	Grand Total, Staffed	Psych		301	55	114	34	40	30	574			7	150	22	18	16	16	229	803
	Grand	Sub Abuse		36	0	0	0	0	0	36			0	0	0	0	0	0	0	96
		Total		48	0	37	0	0	0	85			7	٥	0	0	16	16	39	124
g	Geriatric (65+)	Psych		48	0	37	0	0	0	85			7	0	0	0	16	16	39	124
icensed Be	Ger	Sub Abuse		0	0	0	0	0	0	0			0	0	0	0	0	0	0	0
Assignments And Total Lic 2016 Joint Annual Reports		Total		203	55	77	0	20	30	385			0	150	22	18	0	0	190	929
nents An nt Annua	Adult (18-64)	Psych		172	55	77	0	20	30	354			0	150	22	18	0	0	190	544
Bed Assignments And Total Licensed Beds 2016 Joint Annual Reports	Ad	Sub Abuse		31	0	0	0	0	0	31			0	0	0	0	0	0	0	31
Staffed E	-47)	Total		86	0	0	34	20	0	140			0	0	0	0	0	0	0	140
	Children & Youth (0-17)	Psych		81	0	0	34	20	0	135			0	0	0	0	0	0	0	135
	Chile	Sub Abuse		ري د	0	0	0	0	0	5			0	0	0	0	0	0	0	uo .
		Facility & Service Area	Primary Svc Area - Shelby Co.	Lakeside Behav Hith	Memphis MH Institute	Delta MC	Methodist Univ Healthcare	Saint Francis Hosp	Crestwyn Behavioral Health	PSA Total		Secondary Svc Area - Other	Baptist Mem Hosp-Huntingdon	Western MH Institute	Henry County Med Center	Pathways of TN Behav Hith Svcs	Woodridge, dba Oak Hills, BH	Behavioral Healthcare Cntr - Martin	SSA Total	Service Area Total

Source: Joint Annual Reports, page 38
Notes:
1. Lakeside Bahavioral Health JAR indicates that 8 of their 345 licensed beds are set up for crisis stabilization. These are not included in the 337 total beds shown in the table above.

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8. Section B, Need, Item 2.e Patients with Intellectual Disabilities (Psychiatric Inpatient Services-Service Specific Criteria-) Page 22

Please indicate where the applicant refers patients with Intellectual Disabilities for inpatient psychiatric treatment in the proposed service area.

If unable to accept this type of patient, the applicant must often refer the patient out of State for lack of a provider in the service area with available capacity. The last such referral was to an Atlanta facility. To place such patients, Crestwyn staff members work with patient families and with community agencies such as BSTN (Behavioral Services of Tennessee), Youth Villages, and Alliance Healthcare Services.

In its admission decisions, Crestwyn follows all guidelines of EMTALA (the Emergency Medical Treatment and Labor Act) to ensure patients' access to emergency care regardless of ability to pay. Federal law requires hospitals that participate in Medicare and offer emergency care to provide a medical screening examination when a request is made for examination or treatment for any emergency medical condition (including active labor), without regard to the patient's ability to pay. The hospital must then provide stabilizing care if possible; and if not, an appropriate transfer must be arranged.

9. Section B, Need, Item 2.f Medical Inpatient Transfer Agreements (Psychiatric Inpatient Services-Service Specific Criteria-) Page 23

It is noted the applicant has medical transfer agreements with Baptist and St. Francis. Please indicate their distance from the applicant.

Baptist Memorial Hospital Memphis is 14.0 miles from Crestwyn. St. Francis is 11.1 miles.

10. Section B, Need, Item 2.j Crisis Stabilization Units (Psychiatric Inpatient Services-Service Specific Criteria-) Page 24

It is noted the proposed service area has two TennCare designated Crisis Stabilization teams-Youth Villages and Alliance. Please provide a brief overview of each Crisis Stabilization Service including the number of beds available.

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The Youth Villages Specialized Crisis Services staff provides assessment and evaluation of children and youth up to the age of 18, who are experiencing a psychiatric emergency. They are organized into seven areas that cover the entire State. They are designated by TennCare to provide services to TennCare patients across the State. Youth Villages has no crisis stabilization beds of its own at this point in time, but does operate six residential treatment homes across the State as well as group homes in Nashville and Memphis.

Alliance Healthcare Services is the largest provider of outpatient mental health are in Shelby County, where it operates 55 crisis intervention beds and a continuum of crisis services. Their services also include outpatient medicine management; individual, group and family therapy; care coordination, a continuum of housing services. They are also a designated TennCare provider.

11. Section B, Need, Item 3 Incidence and Prevalence (Psychiatric Inpatient Services-Service Specific Criteria-) Page 24

Please use incidence and prevalence data from the following Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) web-site to respond to the Incidence and Prevalence Criteria: https://www.tn.gov/behavioral-health/research/data--research--and-planning/county-and-regional-behavioral-health-prevalence-dashboard.html In your response, please also compare the proposed service area to the statewide incidence and prevalence trends.

The TDMHSAS website and related links provide a wealth of data on indicators of incidence and prevalence of mental health and substance abuse behaviors. However, it does not appear to offer information that would make that data relevant to establishing the need for this particular type of inpatient project.

TDMHSAS's 2017 Data Book for Behavioral Health Indicators for Tennessee and the United States, and its 2017 Tennessee Behavioral Health County and Region Services Data Book, compare indicators in the Department's seven Planning and Policy Regions (PPR's) to Statewide and national indicators. Crestwyn is in PPR #7, which consists of Shelby County, Crestwyn's primary service area. Crestwyn also serves PPR#6, which is the rest of West Tennessee. Unfortunately, PPR data on hospital admissions trends is limited to facilities owned by or under contract to the Department. The data do not include trends at private hospitals, which in PPRs 6 and 7 provide the great majority of behavioral health bed utilization. Almost all data in the books pertains to behaviors known to carry risks of mental illness.

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The applicant's review of these sources suggests that Tennessee, and PPRs 7 and 8, do not vary greatly from other areas, in their indicators. For perspective, selected pages from these books are attached after this page. They identify areas of concern in which Tennessee is higher or lower in rankings against other States.

In addition, the applicant noted that rates of admission to TDMGSAS-affiliated hospitals in PPRs 6 & 7 (this project's secondary and primary service areas, respectively) were lower than the Tennessee average. The following facts were also identified in the 2017 Tennessee Behavioral Health County and Region Services Data Book. Data cited are for 2016.

<u>Table 38, Chart 30 and Table 44A</u>: For persons age 18+, 2016 admissions (to TDMHSAS-affiliated hospitals) were 2.3 per thousand population Statewide, but only 2.1 in Shelby County and 1.7 in West Tennessee excluding Shelby County,

<u>Table 39</u>: Admissions by gender were 66.4% male and 33.6% female for PPR 7 (Shelby County) and 65.1% male and 34.9% female for PPR 6 (West Tennessee excluding Shelby).

<u>Table 40</u>: In PPR 7, 18.3% of admissions were 18 to 25 years of age; 81.7% were 26 or older. In PPR 6, those percentages were 16.8% and 83.2%, repectively.

Sics

Contact: Karen Edwards, Ph.D., Research Director

615-532-3649

Karen.Edwards@tracog

2017 Tennessee Behavioral Health Substance Abuse Services Mental Health &

Department of

September 2017

County and Region Services Data Book

Division of Planning, Research and Forensics Xinqing Deng, MD, MPH and Rachel L. Jones Prepared by:

Office of Research



Official Accreditation Report

Crestwyn Health Group LLC 9485 Crestwyn Hills Memphis, TN 38125

Organization Identification Number: 590562

Initial Unannounced Full Event: 6/27/2016 - 6/29/2016

ine Joint Commission

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Supplemental #1 March 27, 2018 11:42 am

Report Contents

Executive Summary

Survey Analysis for Evaluating Risk (SAFER™)

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right.

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. (Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Organization Identification Number: 590562

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March 27, 2018
11:42 am

Executive Summary

Program(s)
Hospital Accreditation

Survey Date(s) 06/27/2016-06/29/2016

Hospital Accreditation:

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Organization Identification Number: 590562

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SAFER™ Matrix Description

Supplemental #1

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

All Evidence of Standards Compliance (ESC) forms, which outline corrective actions, will be due in 60 days. For those findings of a higher risk, two additional fields will be required within the ESC for the organization to provide a more detailed description of leadership involvement and preventive analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER Matrix Placement	Required Follow-Up Activity
LOW/LIMITED	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
MODERATE/PATTERN, MODERATE/WIDESPREAD	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey
HIGH/LIMITED.	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate that ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.

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SAFER Matrix

Supplemental #1

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Hospital Accreditation Program

	ITL			
		PC.01.02.09 EP 7		
Visitor/Staff	High			
atient		WT.05.01.01 EP 3	EC.02.04.03 EP 1 PC.01.02.13 EP 6 RC.02.04.01 EP 3	PC.01.02.13 EP 2 PC.01.03.01 EP 1
Likelihood to Harm a Patient/Visitor/Staff	Moderate			
ike.		LS.02.01.20 EP 26 MM.04.01.01 EP 9	MS.06.01.05 EP 7 PC.01.03.01 EP 5	
-	Low	PC.01.02.01 EP 23	RC.02.03.07 EP 4	
		Limited	Pattern	Widespread

Scope

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Requirements for Improvement - Summary 42 am

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. (Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

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Summary of CMS Findings

Supplemental #1

March 27, 2018

CoP:

§482.24

Tag: A-0431

Deficiency: Standard

Corresponds to: HAP

Text:

§482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual

evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(2)	A-0450	HAP - RC.02.03.07/EP4	Standard

CoP:

§482.41

Tag: A-0700

Deficiency: Standard

Corresponds to: HAP

Text:

§482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital

services appropriate to the needs of the community.

CoP Standard	Tag	Tag Corresponds to					
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP1	Standard				
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP26	Standard				

CoP:

§482.61

Tag: B103

Deficiency: Standard

Corresponds to: HAP

Text:

§482.61 Condition of Participation: Special medical record requirements for psychiatric

hospitals.

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

CoP Standard	Tag	Corresponds to	Deficiency
§482.61(e)	B133	HAP - RC.02.04.01/EP3	Standard
§482.61(a)(5)	B109	HAP - PC.01.02.13/EP6	Standard
§482.61(b)(7)	B117	HAP - PC.01.02.13/EP2	Standard
§482.61(c)(1)	B119	HAP - PC.01.03.01/EP1	Standard
§482.61(c)(1)(ii)	B121	HAP - PC.01.03.01/EP5	Standard

CoP:

§482.22

Tag: A-0338

Deficiency: Standard

Corresponds to: HAP

Text:

§482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical

care provided to patients by the hospital.

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Summary of CMS Findings Supplemental #1

	r	r	March 27, 2018
CoP Standard	Tag	Corresponds to	11:42 am
§482.22(a)(1)	A-0340	HAP - MS.06.01.05/EP7	Standard

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Supplemental #1

March 27, 2018

Requirements for Improvement - Detait42 am

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.04.03

Standard Text:

The hospital inspects, tests, and maintains medical equipment.

Element(s) of Performance:

1. For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

For hospitals that use Joint Commission accreditation for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

EP 1

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

During the document review and staff interview it was observed that the hospital did not perform safety, operational and functional checks before initial use for all of the hospital's medical equipment listed on the medical equipment inventory list. It was observed that the hospital started receiving their patients on May 2, 2016 and the documentation verified that the initial inspections of the medical equipment which includes but not limited to 3 AED devices were not conducted until June 2, 2016.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.20

Standard Text:

The hospital maintains the integrity of the means of egress.

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Element(s) of Performance:

26. In new buildings, no dead-end corridor is longer than 30 feet. (For full text and any exceptions, refer to NFPA 101-2000: 18.2.5.10)

Note: Existing dead-end corridors are permitted to be used if it is impractical and unfeasible to alter them. (For full text and any exceptions, refer to NFPA 101-2000: 19.2.5.10)

Likelihood to Cause Harm:

Low

Scope:

Limited

Observation(s):

EP 26

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

During the building tour it was observed that the corridor near the dietary department and hazardous area room 1154 had a dead end corridor that was greater than 30 feet.

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.06.01.05

Standard Text:

The decision to grant or deny a privilege(s), and/or to renew an existing privilege

(s), is an objective, evidence-based process.

Element(s) of Performance:

7. The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

Likelihood to Cause Harm:

Low

Scope:

Pattern

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Observation(s):

EP 7

\$482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members. This Standard is NOT MET as evidenced by:

Observed in Credentialing and Privileging at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 2 of 3 medical staff/credentialing files reviewed, Radiologist chart's had the NPDB queried in 2014, but not before starting work for the hospital in May 2016

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.04.01.01

Standard Text:

Medication orders are clear and accurate.

Element(s) of Performance:

9. A diagnosis, condition, or indication for use exists for each medication ordered.

Note: This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.

Likelihood to Cause Harm:

Low

Scope:

Limited

Observation(s):

EP9

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. One record had multiple medications that did not have indications. The medications were Depakote and Geodon. The MD note did not explain the use of the medications.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.01

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Standard Text:

The hospital assesses and reassesses its patients. 11:42 am

Element(s) of Performance:

23. During patient assessments and reassessments, the hospital gathers the data and information it requires. (See also PC.01.01.01, EP 24)

Likelihood to Cause Harm:

Low

Scope:

Limited

Observation(s):

EP 23

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. One patient who scored low fall risk was not rescreened in one week according to directions on the form. However, the policy for fall risk does not address reassessments.

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. While the CAGE assessment had been done, the actual alcohol assessment had not been done. The patient was admitted 6/21/16 and the assessment should be done within 72 hours according to hospital policy.

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 10 patient records reviewed, of both open and closed medical records the section of the medical history and physical exam that addressed previous surgical procedures was left blank. It is likely that the patient, an adolescent, had not had any procedures in the past, however, that should have been indicated in the medical history and physical examination.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.09

Standard Text:

The hospital assesses the patient who may be a victim of possible abuse and

neglect.

Element(s) of Performance:

7. The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. (See also RI.01.06.03, EP 3)

Likelihood to Cause Harm:

High

Scope:

Limited

Observation(s):

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EP 7

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 1 patient records reviewed, closed medical record of a 17 year old adolescent who had been admitted for severe depression and melancholy in part related to her first sexual encounter which she related to care givers upon admission. The encounter had occurred, ostensibly, with a 25 year old man. There was no discussion in the medical record that the sexual molestation had been reported to the Division of Child Protective Services.

Chapter:

Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.13

Standard Text: The hospital assesses the needs of patients who receive treatment for emotional

and behavioral disorders.

Element(s) of Performance:

2. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:

- Current mental, emotional, and behavioral functioning
- Maladaptive or other behaviors that create a risk to the patient or others
- Mental status examination
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient's care
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient's illness and circumstances leading to admission
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan (See also PC.01.03.01, EP 1)

Likelihood to Cause Harm: Moderate Scope: WideSpread

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6. Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:

- A psychiatric evaluation
- Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.01.02.03, EP 4)

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

EP 2

§482.61(b)(7) - (B117) - (7) Include an inventory of the patient's assets in descriptive, not interpretative, fashion. This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 9 of 10 patient records reviewed, Both open and closed medical records reviewed the inventory of assets checked in the psychiatric evaluation did not give sufficient detail to determine how they should be used in treatment of the patient. The recreation therapist did detail activity preferences including games, television programs, sports in the activities interventions of the plan. However, these don't demonstrate the personal strengths as defined in the interpretive guidelines of conditions of participation: "...although the term strength is often used interchangeably with assets, only the assets which describe personal strengths on which to base the treatment plan or which are useful in therapy represent personal strengths. Strengths are personal attributes i.e. knowledge, skills, aptitudes, personal experiences, education, talents and employment status which may be useful in developing a meaningful treatment plan..."

EP 6

\$482.61(a)(5) - (B109) - (5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 1 of 10 patient records reviewed, One of the 10 open and closed medical records reviewed had an incomplete neurological exam. The cranial nerve evaluation was not completed.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.03.01

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Standard Text:

The hospital plans the patient's care.

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Element(s) of Performance:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2; PC.01.02.13, EP 2)

Likelihood to Cause Harm:

Moderate

Scope:

WideSpread

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.

Likelihood to Cause Harm:

Low

Scope:

Pattern

Observation(s):

EP 1

§482.61(c)(1) - (B119) - (1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities.

The written plan must include—

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 9 of 10 patient records reviewed, Both open and closed it was evident that the treatment plan was not based on the inventory of the patient's strengths and disabilities. The selection of strengths and disabilities that is attached to the Master Treatment Plan is a check list and not further referenced in the goals established in the treatment plan. It also does not correlate with the inventory of strengths and disabilities of the checklist in the psychiatric evaluation. General statements such as "hobbies", "motivation", "talents" etc. should be followed with further detail of what each of those selections reference. Of note; the activities therapists do lists "likes" and "dislikes" in the treatment plans that include specific sports, activities, television etc.

EP 5

§482.61(c)(1)(ii) - (B121) - (ii) Short-term and long-range goals;

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 3 of 6 patient records reviewed, There were goals that were not measurable. Examples include: "David will process life stressors contributing to depression." and "Pt will have alternative coping strategies that reinforce positive outcomes." "will be compliant with detox protocol."

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Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.02.03.07

Standard Text:

Qualified staff receive and record verbal orders.

Element(s) of Performance:

4. Verbal orders are authenticated within the time frame specified by law and regulation.

Likelihood to Cause Harm:

Low

Scope:

Pattern

Observation(s):

EP 4

§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 2 of 7 patient records reviewed, Verbal orders had not been signed within the 48 hours which was the hospital's policy. One telephone order contained 5 different medications and was given on 5/11/16 and was signed on 5/14/16. Another medication had been given on 6/23/15 and had not been signed by 6/27/16 during the survey.

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.02.04.01

Standard Text:

The hospital documents the patient's discharge information.

Element(s) of Performance:

ine Joint Commission

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3. In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:

- The reason for hospitalization
- The procedures performed
- The care, treatment, and services provided
- The patient's condition and disposition at discharge
- Information provided to the patient and family
- Provisions for follow-up care

Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with

the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

EP3

§482.61(e) - (B133) - §482.61(e) Standard: Discharge planning and discharge summary.

The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 3 of 3 patient records reviewed, All closed medical records that had a discharge summary and "Discharge Plan" there was a recapitulation of the patient's hospital course, however, none of the three contained a detail of the goals and specifically goal attainment.

Chapter:

Waived Testing

Program:

Hospital Accreditation

Standard:

WT.05.01.01

Standard Text:

The hospital maintains records for waived testing.

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Element(s) of Performance:

3. Quantitative test result reports in the medical record for waived testing are accompanied by reference intervals (normal values) specific to the test method used and the population served. Note 1: Semiquantitative results, such as urine macroscopic and urine dipsticks, are not required to comply with this element of performance.

Note 2: If the reference intervals (normal values) are not documented on the same page as and adjacent to the waived test result, they must be located elsewhere within the permanent medical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the medical record.

Likelihood to Cause Harm:

Moderate

Scope:

Limited

Observation(s):

EP3

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 1 patient records reviewed, Closed medical record of a very brittle diabetic patient it was noted that the reference ranges for the device used for point of care testing for blood glucose was not in the patient's medical record.

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Plan for Improvement - Summary 1:42 am

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs:

0

The Commercial Appeal Affidavit of Publication

STATE OF TENNESSEE COUNTY OF SHELBY

Personally appeared before me, Glenn W. Edwards, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal, to-wit:

March 10, 2018

Subscribed and sworn to before me this 12th day of March, 2018

My commission expires January 20, 2020

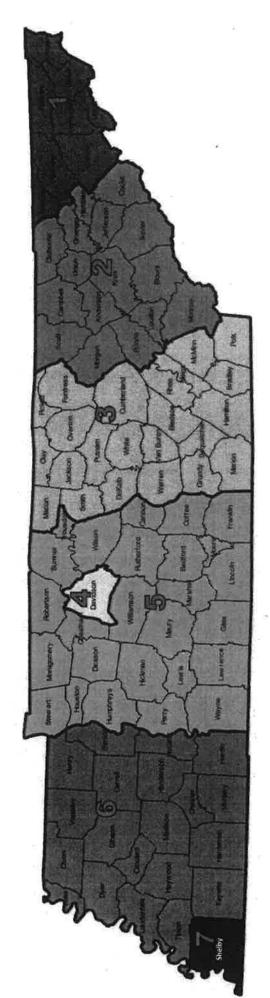
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27, 2018 11:42 am

TDMHSAS Planning and Policy Regions (PPR)

Substance Abuse Services

Department of Mental Health &



Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington counties Region 1:

Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Jefferson, Hamblen, Knox, Louden, Monroe, Morgan, Roane, Scott, Sevier, Region 2:

Bledsoe, Bradley, Clay, Cumberland, DeKalb, Fentress, Grundy, Hamilton, Jackson, Macon, Marion, McMinn, Meigs, Overton, Pickett, Polk, Putnam, Rhea, Sequatchie, Smith, Van Buren, Warren, White counties Region 3:

Davidson County Region 4:

Union counties

Bedford, Cannon, Cheatham, Coffee, Dickson, Franklin, Giles, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Maury, Region 5:

Marshall, Montgomery, Moore, Perry, Robertson, Rutherford, Stewart, Sumner, Trousdale, Wayne, Williamson, Wilson counties

Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Region 6:

Madison, McNairy, Obion, Tipton, Weakley counties

Shelby County Region 7:



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2. Quick facts

The "quick facts" section highlights indicators for which Tennessee ranks at the top or the bottom when compared with other states' most recent data or for which an interesting pattern over years was observed.

These highlights have been categorized in two groups: 1) indicators with a high rank, a low prevalence or improvements in ranking over years; and 2) indicators with a low rank, a high prevalence or decreases in ranking over years.

Indicators with low prevalence or positive outcomes

\Rightarrow	For most substance abuse indicators, Tennessee rankings were consistently in the top 10 or middle 30.
data use i	Tennessee had a lower prevalence of current alcohol users when compared with other states. The shows that Tennessee consistently ranked among the top ten states with a lower prevalence of alcohol in the past month than the national average among youth and adults over the most recent five years of available.
_	

Tennessee was in the top ten states with a **lower prevalence of individuals with an alcohol use disorder** (dependence or abuse of alcohol) in the past year. The percentages of individuals with an alcohol disorder in the past year in Tennessee were lower than national average levels over the recent five years.

\supset	The percentage of people not receiving treatment for a substance use disorder was lower than	1 the
natio	nal average for all age groups, particularly for adults ages 26+.	

In addition, Tennessee decreased its prevalence rates in nonmedical use of pain relievers in the past year and needing but not receiving substance abuse treatment for illicit drugs in the past year.

0	Tennessee was among the top ten states with a lower prevalence of marijuana use in the past month
and a	ilso with a lower average annual incidence of marijuana (first use of marijuana).

Tennessee improved its ranking for youth in grades 9-12 who smoked a cigarette on at least one day in the past 30 days in both 2013 and 2015 YRBS survey, moving up its rank from the bottom 20% to the middle 60% of states. The prevalence of tobacco product use in the past month of cigarette use in the past month decreased significantly among youth (ages 12 - 17).

The only mental health indicator where Tennessee had a lower percentage compared to other states was for youth ages 12-17 who had at least one major depressive episode in the past year.



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Indicators with high prevalence or negative outcomes in Tennessee

- Although improving over the most recent five years, the prevalence of tobacco product use or cigarette use in the past month was still higher than national average level.
- Tennessee's ranking are consistently in the bottom 10 or middle 30 with a higher prevalence than national average level for most mental health indicators, particularly for adults ages 26+.
- Tennessee ranked among the **bottom ten states for children and youth (ages 2-17) who received a mental health diagnosis** by a doctor (e.g., autism, developmental delays, depression, anxiety, ADD/ADHD, or behavioral/conduct problems).
- Tennessee ranked among the bottom 20% of states for a few indicators addressing behavioral health issues for youth in high school (grades 9-12) during 2013. These indicators include:
 - the use of methamphetamines;
 - the use of non-medical prescription drugs during their lifetime;
 - attempted suicides that resulted in an injury that had to be treated by a doctor or nurse.
- In 2015 BRFSS survey, Tennessee was in the bottom 10 states with the highest number of reported poor mental health days for adults (18+ years).
- In 2015 BRFSS survey, Tennessee ranked among the **bottom 10 states with a high prevalence of adults** (18+ years) who are limited in any activities because of physical, mental or emotional problems.
- A higher percentage of adults (26+ years) in Tennessee reported to be suffering from any mental illness in the last year than national average level and Tennessee ranks the bottom 10 states over the recent five years.



The following table highlights the indicators where Tennessee ranks in the bottom 10 states, indicating a high prevalence of substance use and mental health issues, when compared with other states based on the most recent data available.

Table 2. Tennessee ranks among the bottom 10 states in:

Indicator	Children/ Age	Youth in Grades	Adults Age	Adults Age
	2-17	9-12	18+	26+
Used methamphetamines one or more times during their lifetime.		✓		
Used prescription drugs one or more times in their life without a doctor's prescription.		✓		
Children with a mental health diagnosis.	✓			
Youth who attempted suicide that resulted in an injury.		✓		
Youth who were bullied on school property in the past 12 months		√		
Adults who had serious thoughts of suicide.				
Adults who are limited in any activities because of physical, mental or emotional problems.			√	
Number of reported poor mental health days.			1	
Adults with any mental illness in past year.				√



The following table highlights the indicators where Tennessee ranks among the top 10, indicating a lower prevalence of substance use and mental health issues, when compared with other states (based on the most recent data available).

Table 1. Tennessee ranks among the top 10 states with low prevalence in:

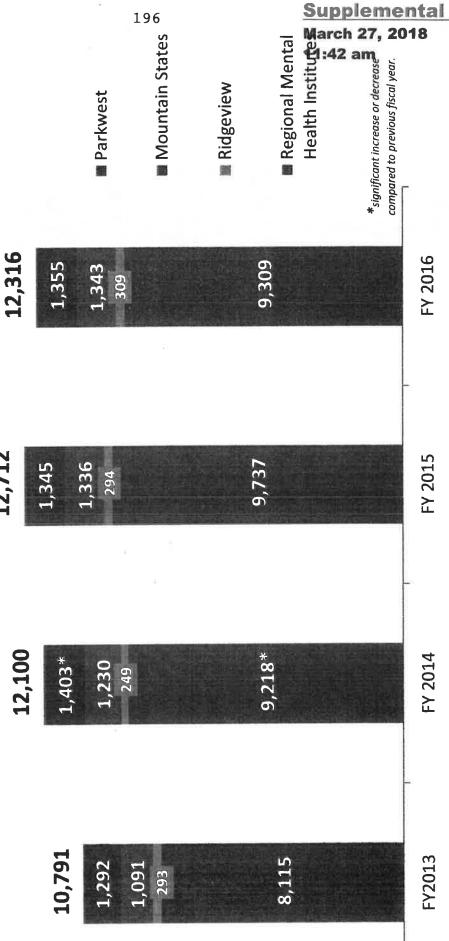
Table 1. Tellifessee falks affolig				
Indicator	Youth Age 12-17	Young adults Age 18-25	Adults Age 18+	Adults Age 26+
Used alcohol in the past month.	✓	✓	· 🗸	✓
With alcohol use disorder in past year.	✓	✓	✓	✓
Needing but not receiving substance abuse treatment for alcohol.			✓	✓
Used illicit drugs in past month.	✓	✓	✓	✓
First use of marijuana	✓	✓	✓	✓
Used marijuana in the past month.	✓		✓	✓
Used marijuana in the past year.	✓	✓		
Had at least one major depressive episode in past year.	√			

Please note that Tennessee ranks in the middle or bottom 20% for most mental health indicators; see next page.

Table 37. TDMHSAS-funded admissions to psychiatric hospitals

	FY2013 F	FY 2014 FY 2015	FY 2015	FY 2016
Regional mental health institutes	8,115	9,218	9,737	608'6
Private psychiatric hospitals that contract with TDMHSAS	2,676	2,882	2,975	3,007
Statewide number of admissions	10,791	12,100	12,712	12,316

Chart 29. TDMHSAS-funded admissions to regional mental health institutes and private psychiatric hospitals that contract with TDMHSAS



Data source: TDMHSAS Division of Hospital Services. Patients age 18 and older were included.

Please note that Lakeshore Mental Health Institute closed with the end of FY2012; TDMHSAS started contracting with private psychiatric hospitals in FY2012.

County and Region Services Data Book 2017 Behavioral Health

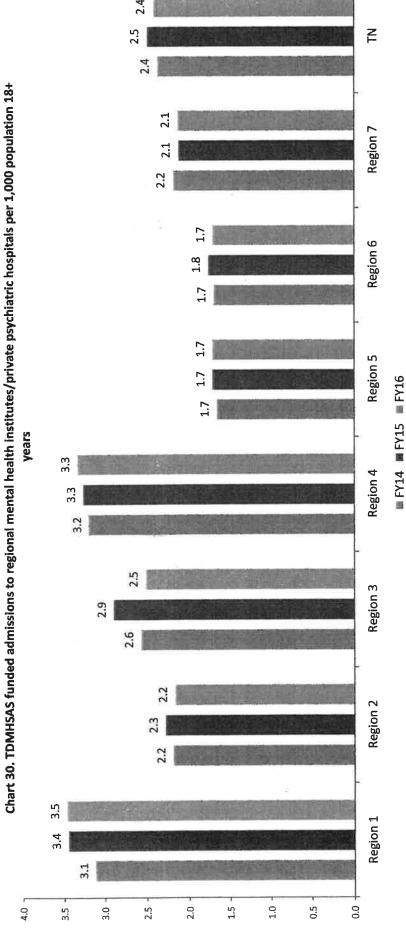
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Table 38. TDMHSAS-funded admissions to regional mental health institutes and private psychiatric hospitals that contract with TDMHSAS

Department of Mental Health & Substance Abuse Services

TDMHSAS Region Tennessee								
	e PPR 1	PPR 2	PPR3	PPR4	PPRS	PPR 6	PPR 7	N/A*
12,100	1,299	2,100	1,972	1,706	2,082	828	1,523	290
100%	10.74%	17.36%	16,30%	14.10%	17.21%	6.84%	12.59%	4.88%
5712 12,712	1,435	2,188	2,220	1,742	2,144	859	1,480	644
100%	11.29%	17.21%	17.46%	13.70%	16.87%	892.9	11.64%	8.07%
12,316	1,418	2,080	1,922	1,778	2,145	833	1,485	655
100% TOO	11.51%	16.89%	15.61%	14.44%	17.42%	6.76%	12.06%	5.32%



Data source: TDMHSAS Division of Hospital Services.

2017 Behavioral Health

^{*}Data note: N/A includes admission from out of state as well as admissions with missing county of residence; PPR=TDMHSAS Planning and Policy Region.

Department of Mental Health & Substance Abuse Services

Table 43. Number of admissions and rate per 1,000 population 18+ years by Planning and Policy Regions and counties

											v.		98																	S		100	ol.		334	en
9	Rate	*	1.1	1.8	*	1,6	*	2.1	9.0	1.7	1.7	2.6	2.2	*	*	*	1.9	1.3	13	6.6	2.1	1.6	1.2	6.0	*	2.6	1,5	2.1	1.3	255	Į a	0.7	2.1	7	2.3	100
FY2016	#	12	59	407	16	209	15	29	06	162	2,145	34	49	12	6	12	54	39	48	130	43	22	25	24	<5	55	115	42	31	1 55	30	833	1,48%	6493	12,281	01
2	Kate	*	1.1	1.7	*	1.6	*	1.9	0.7	1.4	1.7	3.3	2.1	1.6	*	2.5	1.9	1.0	1.4	5.4	1.8	1.1	1.6	1.2	*	1.8	2.1	2.1	1.2	1.0	1.4	1.8	2.1	10	2.4	
FY2015	n.	11	55	388	12	217	15	26	113	139	2,142	42	45	22	9	23	99	30	52	112	36	15	35	30	<5	38	156	42	29	45	39	859	1,480	635	12,646	
	Rate		1.3	1.6	1.5	1.7	3.4	1.6	9.0	1.3	1.7	2.2	2.7	0.7	*	*	1.8	8.0	1.2	5.4	1.5	1.7	1.9	1.0	*	1.4	2.0	2.6	1710	6.0	1.6	1.7	2.2	-	2.2	rices.
FY2014	J #	18	99	357	16	221	21	22	95	125	8707	28	90	10	11	13	53	25	46	111	31	23	40	26	8	30	149	53	26	40	44	827	,522	583	12,031	utes and private psychiatric hospitals that contract with TDMHSAS: Division of Hospital Services
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FY2015	H.	10	29 1	49 2	140	30	18	<5	49	136	108	46	23	11	88	29	2,216	1,740	06	19	45	127	98	73	58	70	10	28	65	29	39	49	177	198	\$	niatric ho
	Kate	*	1.7	3.0	2.5	3.3	*	*	3.3	1.8	4.1	1.7	*	*	2.2	1.0	2.6	3.2 1	2.2	3.1	1.5	3.1	2.2	2.2	2.9	2.1	*	2.3	2.1	4.6	-6.0	1.6	2.7	1.4	*	ate psycl
FY2014	a.	11	29	29		31	11	0	44	105	103	20	15	14	89	21	1,964	1,704	78	34	45	126	87	71		40	11	32	29	43	24	38	180	193	\$	and priv
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FY2016	Rate	3.4	3.0	*	1.6	2.0	3,1	3.5	5.2	3.5	3.7	1.2	3.0	2.5	1.6	2.0	1.9	1.4	1 2.4	1.6	3 2.2	3.0	4 3.2	1.8	3 1.5	*	51 2.2	5 2.1	8 2.2	*	1.5	200	2.3	3.5	0 3.0	vices in r
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FY2015	Rate	3 2.8	7 2.7	*	5 2.8	2.4	9 3.1	3.2	5.1	3.4	3,6	1 1.7	3 3.9	3 2.5	3 2.1	1,4	1.9	1.4	0 2.4	1.3	2 2.3	3 2.8	9 3.5	3 2.3	4 1.5	* /	70 2.3	1.9	9 2.8	*	7 1.2		2 2.3	4.3	7 3.4	nental he
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E,	Jig.	141	126	12	92	47	352	52	n 448	1,270	203	189	96	20	43	31	73	09	853	9	73	47	128	37	113	22	2,083	24	205	1	1d 51	39	17	38		S-funde
	Alueo'	Carter	Greene	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington	Region 1	Anderson	Blount	Campbell	Claiborne	Cocke	Grainger	Hamblen	Jefferson	Knox	Loudon	Monroe	Morgan	Roane	Scott	Sevier	Union	Region 2	Bledsoe	Bradley	Clay	Cumberland	DeKalb	Fentress	Grundy	Hamilton	Data source: TDMHSAS-funded admissions to mental health services in regional mental health instir
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Data note: <5 = number of admissions less than 5 but greater than or equal to 1; 0 events reported if applicable; *Rates not reported for admissions <20; PPR=TDMHSAS Planning and Policy Region. N/A includes admissions from individuals "out of state" or where the county of residence was unknown or not collected.

Page Ten March 26, 2018

12. Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services) B. 2. Service Area Demographics and Section B. Need. Item 4.A Service Area Demographics

Please complete the following chart for each county in the proposed service area.

Demographic Data	Service Area Total	State of TN Total
0-17 Population-2018		
0-17 Population-2020		
0-17 Population % Change		
0-17 Population % of Total Population		
65+ Population-2018		
65+ Population-2020		
65+ Population % Change		
65+ Population % of Total Population		

Please see the applicant's table on the following page.

		ž	Response to Reviewer's	Reviewer's	Question 12	2				
Primary Service Area	Total Population	0-17 Population	0-17 Population	0-17 % Change	0-17 Percent of Total County Population	65+ Population	65+ Population	65+ % Change	65+ Percent of Total County Population	
Shelby / PSA Total	981.022	249.747	252,312	1.0%		125,389	135,234	7.9%		
SSA										,
Benton	16,741	3,045	2,977	-2.2%	17.8%	4,331	4,568			-1
Carroll	28,782	6,105	950'9	-0.8%	21.0%	6,340	699'9			1
Chester	18,978	3,913	3,880	-0.8%	20.4%	3,394	3,590			
Crockett	15,080	3,570	3,554	-0.4%	23.6%	2,932	3,079			
Decatur	12,077	2,410	2,372	-1.6%	19.6%	3,092	3,263			
Dver	39,872	9,316	608'6	-0.1%	23.3%		7,637			1
Favette	48,510	9,859	10,014	1.6%	20.6%		11,171			ای.
Gibson	52,438	12,372	12,397	0.2%	23.6%		10,255			ام
Hardeman	27,278	5,270	5,143	-2.4%	18.9%		5,171			2
Hardin	26,783	5,290	5,204	-1.6%	19.4%	6,337	6,681	5.4%		
Havwood	18,128	4,284	4,178	-2.5%	23.0%	3,343	3,644			6
Henderson	30,298	688'9	6,898	0.1%			5,959			اه.
Henry	34,055	6,846	6,777	-1.0%	19.9%		8,959			اه
ake	8,579	1,207	1,187	-1.7%	13.8%		1,399	4.6%	16.3%	्रा
anderdale	29,186	6,631	6,580	%8.0-	22.5%		4,578	9.9%	15.7%	्वा
McNairy	27,760	5,921	5,860	-1.0%	21.1%			6.2%	22.8%	्रा
Madison	106,352	25,039	25,201	%9:0	23.7%	17,546		8.0%	17.8%	्वा
Objon	31,559	902'9	6,619	-1.3%	21.0%			2.0%	21.9%	्वा
Tipton	71,196	16,996	17,157	%6.0	24.1%		1	10.8%		्री
Weakley	36,360	7,017	6,975	%9:0-	19.2%	6,770				
Crittenden (AR)	49,039	13,203	12,713	-3.7%	25.9%		6,587			믱
awrence (AR)	16,780	3,692	3,601	-2.5%	21.5%				300 m	01
DeSoto (MS)	179,683	46,645	47,316	1.4%	26.3%	21,432	7	7.3%	3 2. 2	ای
Marshall (MS)	35,891	7,677	7,368	-4.0%	20.5%			5.4%	16.	. 01
Benton (MS)	8,324	1,897	1,818	-4.2%	21.8%	1,389		-1.2%	16.0%	er
SSA Total	969,729	221,800	221,154	%E'0-	22.8%	166,319	177,421	6.7%	18.2%	nta
PSA + SSA Total	1,950,751	471,547	473,466	0.4%	24.3%	291,708	312,655	7.2%	16.0%	
Ctoto of TM Total	7 417 A74	1 593 359	1 615 456	1.4%	22.7%	1.175.938	1.267,962	7.8%	17.8%	9

11:42 am

Page Eleven March 26, 2018

13. Section B, Need, Item 6. Composition of Services (Psychiatric Inpatient Services-Service Specific Criteria-) Page 26

a. It is noted Crestwyn's 10.3 day average length of stay is slightly below the average for Memphis psychiatric hospitals as reported in their 2016 JARs (11.0) and well below the average length of stay for rural West Tennessee behavioral units and hospitals (23.0). However, it appears the West Tennessee average length of stay of 23.0 is possibly a result of Western Mental Health Institute which may have longer lengths of stay. Please clarify.

If Western Mental Health Institute is excluded from the calculation of ALOS for rural West Tennesee providers, the rural area average was approximately 8 days. Those providers' length of stay varied between 6 and 29 days. The total service area's average length of stay, again excluding WMHI, was 10 days--the same as Crestwyn's.

b. Also, please discuss the differences between Memphis Mental Health Institute (MMHI) and Western Mental Health Institute (WMHI) in terms of length of stays and services available. Information may be obtained at the following web-site: https://www.tn.gov/behavioral-health/hospitals.html

MMHI offers 55 beds in two short-term care units; its last reported average length of stay was 12 days. It is a State-owned facility that is responsible primarily for Memphis area residents. It takes both voluntary and involuntary admissions; most of its its patients have a severe and persistent mental illness and are taken in on an emergency, involuntary basis. Its patients are typically not served by private hospitals and have no other resources for inpatient treatment.

WMHI is also a State-owned behavioral health hospital. It is located in Bolivar, Hardeman County, where it serves primarily West Tennessee residents who live outside of Shelby County. WMHI also differs in that it treats long-term as well as short-term patients. It has two short-term care units and four long-term care units with a total of 187 licensed beds, of which 150 are staffed. It offers services similar to those of MMHI, but it has a much longer average length of stay (49 days) due to its patient mix of short- and long-term patients.

11:42 am

Page Twelve March 26, 2018

14. Section B, Need, Item 8. Services to High-Need Populations (Psychiatric Inpatient Services-Service Specific Criteria-) Page 26

Please indicate the percentage of 2017 inpatient admissions that were involuntarily committed to Crestwyn.

In 2017, Crestwyn had 355 involuntary admissions, which was 20.6% of its 1,724 total admissions last year.

- 15. Section B, Need, Item 9. Relationship to Existing Similar Services (Psychiatric Inpatient Services-Service Specific Criteria-) Page 27
 - a. Please indicate the 2017 licensed and staffed occupancies for 0-17, 18-64, and 65+ for Shelby County.

This data is not fully available in the Joint Annual Reports. The JAR for 2017 shows beds set up and staffed on a "typical" day but these are not the same as licensed beds. Beds for adults of all ages may vary at will within a total authorized adult complement, so 18-64 and 65+ utilization cannot be separately calculated. Occupancies on licensed beds for patients 0-17 of age, and for all adult patients combined, have been provided for the entire service area, in response to question #7 above.

b. Please discuss how the applicant's services differ from existing inpatient psychiatric services (e.g. specialized treatment of an age-limited group. Acceptance of involuntary admissions, and differentiation by payor mix) available in Shelby County.

Unlike some service area providers, Crestwyn serves all age groups (although currently children younger than 10 are not currently accepted). Crestwyn is one of only two private hospitals in Memphis with programs for all three major age cohorts. It is the smallest private inpatient facility in PPR 7. Crestwyn not only provides inpatient services; it also provides Intensive Outpatient Programs for adults and adolescents (mornings and evenings), and an adult partial hospitalization program. Crestwyn is very accessible, with a payor mix of 46.3% Medicaid/TennCare. Last year, involuntary admissions were 20.6% of its admissions. In 2017, Crestwyn's psychiatric inpatient beds became the most highly utilized in Shelby County.

Page Twelve March 26, 2018

16. Section B, Need, Item 12. Institution for Mental Disease Classification (Psychiatric Inpatient Services-Service Specific Criteria-) Page 29

The applicant states the proposed project will not adversely affect TennCare's cost-sharing with Federal Medicaid. However, the bed complement data chart on page 14 indicates the addition of 3 adult and geriatric psychiatric beds. Please clarify.

The hospital has an IMD classification. The project will expand child and adolescent bed complements (Federally defined as patients under 21 years of age) by 14 additional beds, while reducing total adult services by 2 beds (the net difference in bed changes for both adult psychiatric and adult dependency units). The net effect of the project will therefore be an increase in beds for children and youth.

- 17. Section B, Need, Item 16. Community Linkage Plan. (Psychiatric Inpatient Services-Service Specific Criteria-) Page 31
 - a. The support letters provided are noted. However, please provide any letters from physicians, mobile crisis teams, and managed care organizations in support of the application detailing instances of unmet need for psychiatric inpatient services in the proposed service area. If possible, please provide measurable instances of unmet need rather than providing broad statements.

Respectfully, the applicant cannot provide more specific letters detailing instances of unmet need or quantifying unmet needs. That is not what the supporting public is typically willing to do.

Not only business relationship issues with providers, and medical confidentiality issues, but also personal liability issues, are legitimate concerns to professionals when voicing their feelings about existing providers.

The letters that supportive community groups have provided for this application clearly document their personal experiences with trying to find adequate inpatient resources for persons in need of care.

Page Fourteen March 26, 2018

b. Please provide the applicant's proposed primary prevention initiatives in the community linkage plan that addresses risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

Crestwyn's role in that regard is very limited. As an acute care hospital, Crestwyn does not manage or undertake prevention initiatives focused on risk reduction for potential patients. However, inpatients who have been cared for at Crestwyn are offered a continuum of robust post-discharge support programs to reduce their risks of being re-admitted. For example, Crestwyn provides an adolescent intensive outpatient program ("IOP") weekday evenings, a partial hospital program ("PHP") for adults on weekday mornings, an adult IOP weekday evenings, and a daytime IOP weekday mornings. These provide former inpatients with continuing support that helps reduce their risks of recurring hospitalization.

18. Section B, Need, Item 18. Quality Control and Monitoring. (Psychiatric Inpatient Services-Service Specific Criteria-) Page 32

Please provide the referenced Crestwyn licensure surveys. In addition, please provide information on the surveys and quality improvement programs of psychiatric inpatient facilities the applicant owns or administers whether located in Tennessee or not.

Crestwyn's most recent accreditation survey report is provided at the end of this letter, together with surveys of Crestwyn's other two Tennessee psychiatric hospitals.

19. Section C. Economic Feasibility Item 1 (Funding), Page 48

The applicant refers to Attachment Section B-Economic Feasibility-1D and Attachment Section B-Economic Feasibility-1E. However, those attachments could not be located. Please clarify.

Those references were errors. This project has no construction component and neither referenced attachment is required. Attached following this page is a revised page 48 R deleting those references.

Page Fifteen March 26, 2018

20. Section B. Economic Feasibility Item D. (Projected Data Chart)

The Projected Data Chart for the total facility is noted. However, please also provide a Projected Data Chart for the proposed project (14 bed addition) only.

The applicant did not submit a Chart for the project because one was deemed unnecessary by HSDA management in a pre-application discussion. Due to the very small scope of this project, to be implemented in existing space in a small facility, one Projected Data Chart for the expanded hospital itself was considered adequately informative.

21. Section B, Economic Feasibility, Item 6.C. Page 60

a. The capitalization ratio of .5756 is noted. However, please multiply x 100 to calculate the capitalization ratio.

Attached following this page is a revised page 60R making that correction.

b. The applicant indicates Net Assets of \$11,668,504 and Long-Term Debt of \$15,827,658. However, those figures could not be located in the applicant financial documents. Please clarify.

Attached after this page is a copy of the hospital's balance sheet, with the appropriate lines marked.

Supplemental

arch 27, 2018 11:42 am

~ My Asul

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29,781.05

(B2861,287,95)

11,668,503.72 (8,331,496.28) (3,361,287,33) 29,791.05 (3,331,486,28) 11,668,509.72 28,777,728,94

15,627,857.53 17,103,563,39 24,784,17 9,000,000,00 19,288,748.24 9,849.98 (955,822.17) (275.91) 55,295,47 11,188,39 22,345,00 1,924,745,93 731,861.86 22,347,820,12 4,520,000.00 (102,124,78) 1,275,905,80 2,967,878,25 (588,905.98) 1 448 549 87 (435,923,89) 11.571,621.871 1,883,567,59 23,719,142,09 \$38.11 210,427.19 (210,089,02) (210,689.02)

201,347.98 9,070,15 338,11 346,820,47 73,606,00 16,715.02 721,961,36 (936,822,17) (276,81) (435,923,99) (1,371,821,97) 22,347,320,12 \$,000,000,00 19,286,748.24 5,845.98 4,500,000.00 1,924,408.62 448,549.57 23,719,142,09 22,345,00 Total Land Total Bulkings Total Bidg and Lease improvements Total Equipment AD Bidg and Lease Improvements Acquire fated Depreciation Total Cost Rat Pay Total Current Liabilities Total Accid Salifanne Total Pr Taxes & With Total finencay Total Deposits Total Ceposite Total Currark Assete Total Acod Expenses

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CRESTWYN GONSGL Grasbyn Consolidated

0146 Grastwyn Holdings 338.11

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1744 Grestwyn

2,957,878.26 (588,905.98)

(48E, 404, 59) 89 185 E88.1

Gross AR Contracted Allowances Total Bed Debt

AR Net

Total Cash

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Page Seventeen March 26, 2018

25. Section B, Orderly Development, Item 4.C-6B (Transfer Agreements), Pages 67 and 68

It is noted the applicant did not answer questions on page 67 and 68 of the application. Please provide responses and provide replacement pages labeled 67R and 68R.

Attached following this page are the requested responses, on replacement pages 67R-68R.

26. Section B, Quality Measures

Please verify and acknowledge the applicant will be evaluated annually whether the proposal will provide health care that meets appropriate quality standards upon the following factors:

- (3) Quality. Whether the proposal will provide health care that meets appropriate quality standards may be evaluated upon the following factors:
- (a) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;
- (b) Whether the applicant will obtain and maintain all applicable state licenses in good standing;
- (c) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;
- (d) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;
- (e) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

- C. Document and explain inspections within the past three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23- ore 90-day termination proceedings from Medicare or Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.
- (1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Crestwyn was licensed in 2016. No such events have occurred.

5. Respond to all of the following and for such occurrences, identify, explain, and provide documentation:

The applicant has made a good faith effort to respond to this question regarding the entities identified in its organization chart, to the best of its knowledge, information and belief. Due to the breadth of the question and a lack of definition of key terms, the applicant cannot represent that these responses are totally comprehensive, but no responsive information is being intentionally withheld. Because there is no central repository for the information sought, and because of the length of time some of the entities have been in existence, the applicant's responses are limited to the past 5 years as a reasonable look-back period.

A. Has any of the following:

- (1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);
- (2) Any entity in which any person(s) or entity with more than 5% ownership (direct of indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or
- (3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%...

B. Been subjected to any of the following:

(1) Final Order or Judgment in a State licensure action;

The applicant assumes for the purpose of this question that "state licensure action" refers to facility licensure. Crestwyn Behavioral Health, and/or its owners (Baptist Memorial Health Services, Inc.; AmiSub (SFH), Inc.; Acadia Crestwyn Holdings) have not been subjected to Final Order or Judgment in a state licensure action. The other entities in the chain of ownership do not hold a hospital license.

(2) Criminal fines in cases involving a Federal or State health care offense;

No.

Page Eighteen March 26, 2018

- (f) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external assessment against nationally available benchmark data to accurately assess its level of performance in relation to established standards and to implement ways to continuously improve.
- 1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable.
- (p) For Inpatient Psychiatric projects:
 - 1. Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;
 - 2. Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems; and
 - 3. Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.

The applicant verifies and acknowledges that there will be an annual evaluation as to whether the project is providing health care that meets the above quality standards.

27. Project Completion forecast Chart

Please provide a completed Project Completion Forecast Chart.

This is provided on the following page.

Page Nineteen March 26, 2018

28. Proof of Publication

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

Attached after the end of this letter is the full newspaper page in which the notice of intent appeared, as directed.

Additional Information from the Applicant

- A. The applicant found that the patient origin table on page 36 of the application failed to include DeSoto County, Mississippi, which is the second largest contributor of admissions to Crestwyn (but at less than 5% of total admissions). That table, and the narrative on page 34, have been adjusted and the replacement pages 34R and 36R are attached after this page. The change made no significant change in the narrative.
- B. Following the amended patient origin information are additional support letters received from the Mental Health Cooperative, Inc.; Carey Counseling Center; Youthtown Residential Treatment Center; and the Mayor of Germantown.
- C. Attached preceding the new support letters is a revised page 65R, updating information on training rotations at Crestwood in the current year.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully, Well Com

John Wellborn



275 Cumberland Bond Drive | Nachville | Tennissee | 37238 | Phone: 615-726-5240 | Generalise thiorg

March 21, 2018

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

MENTAL HEALTH

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of the Mental Health Cooperative, Inc (MHC), I want to express our strong support for the certificate of need application for Crestwyn Behavioral Health.

MHC provides outpatient mental health services for children and adults who are experiencing a serious mental illness. MHC has 10 locations throughout Middle and East Tennessee and we provide services to over 10,000 Consumers. In addition to our outpatient services, MHC is the designated crisis provider for both children and adults in the Nashville area. In our role as a crisis provider, our staff often refer children and youth to Crestwyn for inpatient care and we value the relationship that we have built with Crestwyn admissions staff.

MHC would like to express our support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community throughout Tennessee.

Sincerely, Curanda Bractit

Amanda Myatt Bracht, LCSW

Senior Vice President of Clinical Services

Mental Health Cooperative, Inc.

Direct Office Number: 615-744-7442

E-mail: abracht@mhc-tn.org

408 Virginia Stree	ţ
P. O. Box 30	
Parls, TN 38242	
(731) 642-0521	
Fax: (731) 642-101	0

Street 1263 Hwy. 45 ByPass N.
30 P. O. Box 439
1242 Trenton, TN 38382
1521 (731) 855-2871
1-1010 Fax: (731) 855-2877
March 21, 2018

19410 W. Main Street
P. O. Box 793
Huntingdon, TN 38344
(731) 986-4411
Fax: (731) 986-2878

300 Highway 641 P. O. Box 207 Camden, TN 38320 (731) 584-6999 Fax: (731) 584-3592 1409 N. Morgan Street
P. O. Box 186
Union City, TN 38281
(731) 885-8810
Fax: (731) 885-8588

457 Hannings Lane
P. O. Box 648
Martin, TN 38237
(731) 480-0011
Fax: (731) 480-0014

727 Main Street
McKenzle, TN 38201
(731) 352-3050
Fax: (731) 352-9304

Ms. Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost Building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Carey Counseling Center, Inc. (CAREY), I want to express our strong support for the certificate of need application.

CAREY is a community mental health center serving Northwest TN counties including Benton, Carroll, Gibson, Henry, Lake, Obion and Weakley. We provide outpatient services including TN Healthlink, Medication services and Outpatient therapy along with other grant programs. We also have Residential Programs for the Seriously and Persistently Mentally III (SPMI) population. We provide Mobile Crisis Services to four of our counties, Benton, Carroll, Gibson and Henry.

CAREY would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse program throughout West Tennessee. Having additional beds at Crestwyn would be an invaluable resource for our agency and the rest of the mental health and substance abuse community in our area as well.

Cordially,

Robert D. Vaughn Executive Director

Cc: Sean Jones

Director of Crisis Services Carey Counseling Center, Inc.



To Whom It May Concern:

03/10/18

Youth Town of Tennessee is located just south of Jackson, TN and serves adolescents by providing professional residential treatment for co-occurring disorders. I serve as executive director of Youth Town and also continue a part-time private practice, caring for both adults and children 10-15 hours each week.

I am grateful for the fresh, new presence of Crestwyn Behavioral health in the Memphis, TN area. As we are located in the hub of central West Tennessee, I am acutely aware of the need for inpatient psychiatric services and medical detoxification services for adolescents. It is not uncommon, when faced with a referral, to call multiple hospitals only to learn their beds are full. I have been pleased when I have been able to send a referral to Crestwyn and continue to follow the child as he or she continues in residential treatment post-discharge. So, without reservation, I recommend that Crestwyn Behavioral Health be considered for additional beds.

Please feel free to contact me if you have any additional questions.

Faith, Hope and Love,

Pepper Pratt, Ph.D., LPC/MHSP

Executive Director

Youth Town of Tennessee



GERMANTOWN TENNESSEE 1930 South Germantown Road • Germantown, Tennessee 38138-2815 Phone (901) 757-7200 Fax (901) 757-7292 www.germantown-tn.gov

March 27, 2018 11:42 am

March 19, 2018

Melanie Hill **Executive Director** Tennessee Health Services & Development Agency Frost building, 3rd Floor 161 Rosa Park Blvd. Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of the City of Germantown, I want to express our strong support for the certificate of need application referenced above. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but surrounding communities as well.

Sincerely,

Mike Palazzolo

Mayor

Office 901-757-7252 Fax 901-757-7292

Mayor@Germantown-TN.gov

AFFIDAVIT

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY:	Crestuan	Reharioral	Health
TO THE OT THE PERSON OF			

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

John Zwellbon Signature/Title

Sworn to and subscribed before me, a Notary Public, this the day of witness my hand at office in the County of Davidson, State of Tennessee.

NØTARY PUBLIC

My commission expires July 2

HF-0043

Revised 7/02



Official Accreditation Report

DMC - Memphis, Inc. 3000 Getwell Road Memphis, TN 38118

Organization Identification Number: 7875

Unannounced Full Event: 12/1/2015 - 12/3/2015

The Joint 200 mmission

Supplemental #1 March 27, 2018 11:42 am

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

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Executive Summary

Program(s)
Hospital Accreditation

Survey Date(s) 12/01/2015-12/03/2015

Behavioral Health Care Accreditation

Hospital Accreditation:

As a result of the accreditation activity conducted on the above date(s), you have met the criteria for Accreditation with Follow-up Survey.

If your organization wishes to clarify any of the standards you believe were compliant at the time of survey, you may submit clarifying Evidence of Standards Compliance in 10 business days from the day this report is posted to your organization's extranet site.

You will have follow-up in the area(s) indicated below:

- As a result of a Condition Level Deficiency, an Unannounced Medicare
 Deficiency Follow-up Survey will occur. Please address and correct any
 Condition Level Deficiencies immediately, as the follow-up event addressing
 these deficiencies will occur within 45 days of the last survey date identified
 above. The follow-up event is in addition to the written Evidence of
 Standards Compliance response.
- Evidence of Standards Compliance (ESC)

Behavioral Health Care Accreditation:

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

• Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

	Program	
Standards:	EC.02.05.01	EP15
	FC.02.05.09	EP1,EP3

Hospital Accreditation

Program:

LS.02.01.20 EP1,EP13,EP31

LS.02.01.34 EP2 MS.03.01.01 EP2

PC.01.02.08 EP1

PC.02.01.11 EP2

PC.04.01.05 EP8

Program: Behavioral Health Care Accreditation

Program

Standards: CTS.04.03.33 EP3

NPSG.15.01.01 EP1

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program: Hospital Accreditation

Program

Standards: EC.02.02.01 EP5

EC.02.05.05 EP5

EC.02.06.01 EP1,EP13

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Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

adivey report	was originally posted	to your organization s extranet site.
	HR.01.02.05	EP1
	IC.02.01.01	EP1
	LD.01.03.01	EP2
	LS.02.01.10	EP3,EP5,EP9
	LS.02.01.30	EP11
	LS.02.01.35	EP5
	MM.03.01.01	EP2
	MS.01.01.01	EP3,EP16
	MS.08.01.03	EP2
	PC.01.02.13	EP2
	PI.02.01.01	EP4
	RC.01.01.01	EP19
Program:	Behavioral Health Care Accreditation Program	
Standards:	CTS.02.01.11	EP1
	CTS.03.01.01	EP1
	CTS.03.01.03	EP3

The Joint <u>Commission</u> Summary of CMS Findings

Supplemental #1

March 27, 2018 11:42 am

CoP:

§482.11

Tag: A-0020

Deficiency: Standard

Corresponds to: HAP

Text:

§482.11 Condition of Participation: Compliance with Federal, State and Local Laws

CoP Standard	Tag	Corresponds to	Deficiency
§482.11(c)	A-0023	HAP - HR.01.02.05/EP1	Standard

CoP:

§482.24

Tag: A-0431

Deficiency: Standard

Corresponds to: HAP

Text:

§482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated

or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard

CoP:

§482.41

Tag: A-0700

Deficiency: Condition

Corresponds to: HAP

Text:

§482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A -0701	HAP - EC.02.02.01/EP5, EC.02.06.01/EP1	Standard
§482.41(b)(5)	A-0712	HAP - LS.02.01.30/EP11	Standard
§482.41(c)(2)	A-0724	HAP - EC.02.05.09/EP1, EP3	Standard
§482.41(c)(4)	A-0726	HAP - EC.02.06.01/EP13	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP3, EP5, EP9, LS.02.01.20/EP1, EP13, EP31, LS.02.01.30/EP11, LS.02.01.34/EP2, LS.02.01.35/EP5	Standard

CoP:

§482.42

Tag: A-0747

Deficiency: Standard

Corresponds to: HAP - IC.02.01.01/EP1,

EC.02.05.01/EP15

The Joint Commission **Summary of CMS Findings**

Supplemental #1 March 27, 2018 11:42 am

Text:

§482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP:

§482.21

Tag: A-0263

Deficiency: Standard

Corresponds to: HAP - PI.02.01.01/EP4

Text:

§482.21 Condition of Participation: Quality Assessment and Performance Improvement

Program

The hospital must develop, implement, and maintain an effective, ongoing, hospitalwide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

CoP:

§482.12

Tag: A-0043

Deficiency: Condition

Corresponds to: HAP - LD.01.03.01/EP2

Text:

§482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

CoP Standard	Tag	Corresponds to	Deficiency
§482.12(a)(4)	A-0048	HAP - MS.01.01.01/EP3	Standard

CoP:

§482.22

Tag: A-0338

Deficiency: Standard

Corresponds to: HAP

Text:

§482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)		HAP - MS.03.01.01/EP2, MS.08.01.03/EP2	Standard
§482.22(c)(5)(i)	A-0358	HAP - MS.01.01.01/EP16	Standard

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Requirements for Improvement - Detail

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.02.01

ESC 60 days

Standard Text:

The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 5

§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery decontamination room that the eyewash station that was an unapproved two step unit that required turning on the faucet and then pressing a bypass valve on the spout to initiate water flow. The unit was require due to the use of Prolystica and Surgistain which both required a 15 minute flush in the SDS information. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the old ICU dialysis area on the 2nd floor that there was no eyewash station. The unit was require due to the use liquid chlorine bleach which required a 15 minute flush in the SDS information. This was verified by the Director of Plant Operations.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.05.01

Standard Text:

The hospital manages risks associated with its utility systems.

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Element(s) of Performance:

15. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies. (See also EC.02.06.01, EP 13)

Note: Areas designed for control of airborne contaminants include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in 'protective environment' rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 15

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Surgery area that the clean sterile room was negative to the decontamination room. This was identified on a Test and Balance report on 5/11/15 and not corrected. This was verified by the Director of Plant Operations. This was corrected during the survey by tightening the belt on the supply unit and verifying the proper test & balance.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Surgery area that the clean storage room was negative to the corridor. This was identified on a Test and Balance report on 5/11/15 and not corrected. This was verified by the Director of Plant Operations. This was corrected during the survey by tightening up the belt on the supply unit and verified by test & balance.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Surgery area that the sub-sterile room between OR #3 & OR #4 was positive to both OR's. This was verified by the Director of Plant Operations. This was corrected during the survey by tightening up the belt on the exhaust fan and verifying the test & balance.

1

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Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.05.05

Standard Text:

The hospital inspects, tests, and maintains utility systems.

Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have

access to such documentation during survey and as needed.

Element(s) of Performance:

5. The hospital inspects, tests, and maintains the following: Non-high-risk utility system components on the inventory. These activities are documented.

(See also EC.02.05.01, EPs 2 and 4)

Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 5

Observed in Individual Tracer at DMC - Memphis, Inc. I 3000 Getwell Road, Memphis, TN (Main) (3000 Getwell Road, Memphis, TN) site.

Observed in Document Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.

It was observed that smoke and fire testing was done on 9/25/15 and that no repairs to failed dampers had been done as of 12/2/15. This was verified by the Director of Plant Operations.

Observed in Document Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. It was observed that smoke and fire testing was done on 9/25/15 and that no repairs to failed dampers had been done as of 12/2/15. This was verified by the Director of Plant Operations.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.05.09

Standard Text:

The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum

systems discussed below. However, if a hospital has these types of systems, then

the following inspection, testing, and maintenance requirements apply.

Organization Identification Number: 7875

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Element(s) of Performance:

1. In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3)



Scoring Category: A

Score:

Insufficient Compliance

 The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 1

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Medical Gas testing report dated 10/23/15 that PACU had no alarm panel or vacuum zone valve and that Surgery had no functioning alarm lights for medical air and vacuum. Surgery also had no audible alarm sounds for any gases. In review of the testing report from 10/24/14 that the same deficiencies had been identified and that a proposal had been given for their repair. There had been no repairs to these deficiencies since 2014. This was verified by the Director of Plant Operations.

EP3

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

During tour of the surgical suite, it was noted that storage carts and shelving located along wall in the main corridor of the operating room were blocking access to the medical gas shutoff valves located behind them.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.06.01



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Supplemental #1

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Standard Text:

The hospital establishes and maintains a safe, functional environment.

Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services

appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.



Scoring Category: C

Score:

Insufficient Compliance

13. The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided. (See also EC.02.05.01, EP 15)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

The Joint 200 mmission

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EP 1 §482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

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Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

During tour of the surgical suite and evaluation of the process for decontamination of GI endoscopes, it was noted that the storage cabinet for the clean endoscopes was blocking access to an electrical panel in the operating room.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in Operating room #1 that the electrical panel was blocked by a C-arm and other equipment. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in Operating room #2 that the electrical panel was locked and OR staff did not have a key to access to be able to reset a circuit breaker. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #1 that there were 2 blue multi outlet power taps that were daisy chained with a white multi power tap that was installed on an anesthesia machine. One of the units was clamped to the anesthesia machine and another to a roll around pole with a bair hugger plugged into it which pulled 9.5 amps. The units are UL1363A and rated at 15 amps. The units had multiple other pieces of equipment plugged into them and open available outlets that could used to plug in other devices. They were not part of a tested assembly.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #2 that there was a blue multi outlet power tap that was clamped to a roll around pole with a bair hugger plugged into it which pulled 9.5 amps. The unit is UL1363A and rated at 15 amps. The unit had multiple other pieces of equipment plugged into it and open available outlets that could used to plug in other devices. It was not part of a tested assembly.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #3 that there was a blue multi outlet power tap that was clamped to a roll around pole with a bair hugger plugged into it which pulled 9.5 amps. The unit is UL1363A and rated at 15 amps. The unit had multiple other pieces of equipment plugged into it and open available outlets that could used to plug in other devices. It was not part of a tested assembly.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #1 that there were twist lock to standard pronged plug extension cord adapters that were used to power equipment that were not on the Biomedical equipment list as tested assemblies. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #3 that there were twist lock to standard pronged plug extension cord adapters that were used to power equipment that were not on the Biomedical equipment list as tested assemblies. This was verified by the Director of Plant Operations.

EP 13

§482.41(c)(4) - (A-0726) - (4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.

This Standard is NOT MET as evidenced by:

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Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that on the 4th floor nursing unit that the clean utility room was negative to the corridor. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that on the 4th floor nursing unit that the clean linen room was negative to the corridor. This was verified by the Director of Plant Operations

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that on the 2nd floor medical/surgical unit that the clean supply room was negative to the corridor. This was verified by the Director of Plant Operations

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2-West Psych unit that the soiled utility room was positive to the corridor when it should have been negative. This was verified by the Director of Plant Operations.

Chapter:

Human Resources

Program:

Hospital Accreditation

Standard:

HR.01.02.05

Standard Text:

The hospital verifies staff qualifications.

Supplemental #1

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Element(s) of Performance:

1. When law or regulation requires care providers to be currently licensed, certified, or registered to practice their professions, the hospital both verifies these credentials with the primary source and documents this verification when a provider is hired and when his or her credentials are renewed. (See also HR.01.02.07, EP 2)

Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented.

Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.

Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 1

§482.11(c) - (A-0023) - (c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.

This Standard is NOT MET as evidenced by:

Observed in Competency Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

There was a lack of documentation to demonstrate verification of the dietician's license with the primary source at the time of license renewal. The dietician's license expired 9/30/2014 but was verified with the primary source 8/18/2015. (Note: There was no lapse in licensure.)

Chapter:

Infection Prevention and Control

Program:

Hospital Accreditation

Standard:

IC.02.01.01

Standard Text:

The hospital implements its infection prevention and control plan.

Supplemental #2 March 27, 2018 10:19 am

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 1

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control

This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

Dual diagnosis unit: The shower curtain in a patient's bathroom was visibly contaminated with black mold.

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

Mental health unit 1: A 2nd shower curtain in a patient's bathroom was visibly contaminated with black mold.

Chapter:

Leadership

Program:

Hospital Accreditation

Standard:

Standard Text:

LD.01.03.01

The governing body is ultimately accountable for the safety and quality of care,

treatment, and services.

Element(s) of Performance:

2. The governing body provides for organization management and planning.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

FP 2

§482.12 - (A-0043) - §482.12 Condition of Participation: Condition of Participation: Governing Body

This Condition is NOT MET as evidenced by:

Observed in Auto Score for CLD at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews:§482.41 - (A-0700), §482.12 - (A-0043)

Supplemental #1

March 27, 2018 12:06 pm

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.10

Standard Text:

Building and fire protection features are designed and maintained to minimize the

effects of fire, smoke, and heat.

Element(s) of Performance:

3. Walls that are fire rated for 2 hours (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above and extend from exterior wall to exterior wall. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.2.2)



Scoring Category: A

Score:

Insufficient Compliance

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)



Scoring Category: C

Score:

Insufficient Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.

Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

Supplemental #1 March 27, 2018 11:41 A.M.

EP3

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 4th floor nursing unit that the 1 hour smoke/fire wall was not sealed properly to the deck above patient room #413. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 4th floor nursing unit that the 1 hour smoke/fire wall was not sealed properly to the deck above patient room #418. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that at the old ICU - Dialysis unit that above the 11/2 hour fire doors that the 2 hour fire wall was not sealed to the deck. This was verified by the Director of Plant Operations.

EP 5

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Supplemental #1 March 27, 2018 11:41 A.M.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor near the old ICU dialysis unit that the cross corridor fire doors in the two hour fire wall did not latch when allowed to close due to a faulty coordinator. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that at the old ICU - Dialysis unit that the 11/2 hour fire doors in the 2 hour fire wall had the latching hardware removed and were being held shut with a magnetic lock system. It was evident by the plates on the door where the hardware used to be. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that at the old ICU - Dialysis unit that the 11/2 hour fire doors in the 2 hour fire wall had the latching hardware removed and were being held shut with a magnetic lock system. It was evident by the plates on the door where the hardware used to be. This was verified by the Director of Plant Operations.

EP9

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor medical/surgical unit that the 1 hour smoke/fire wall was had 3 medical gas pipes that were not sealed properly above patient room #267. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor medical/surgical unit that the 1 hour smoke/fire wall was had a 1/2 inch and a 3/4 inch conduit that had open ends that were not sealed properly above patient room #267. This was verified by the Director of Plant Operations

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.20

Standard Text:

The hospital maintains the integrity of the means of egress.

Supplemental #1

March 27, 2018 11:42 am

Element(s) of Performance:

1. Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)

1

Scoring Category: A

Score:

Insufficient Compliance

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)



Scoring Category: C

Score:

Insufficient Compliance

31. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high (or 6 inches high if externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

Supplemental #1

March 27, 2018 11:42 am

EP 1

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/lbr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that the Surgery main entrance cross corridor doors had a slide bolt on one door and a padlock on the other door that were locked at night to secure the area. This made egress through these doors impossible even though they were a marked exit path. The locks were removed during the survey.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that at the marked exit doors leading out of the 2nd floor old ICU dialysis unit that they were magnetic locked and did not release when traveling in the egress direction unless you pushed an exit button located 9 feet away from the doors. There was no proximity sensor that allowed you to egress. They were connected to the fire alarm system and would release on fire alarm. This was verified by the Director of Plant Operations.

EP 13

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Supplemental #1 March 27, 2018

March 27, 2018 11:42 am

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery area exit corridor that was unsprinkled that there was a linen cart and a storage shelf that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery area exit corridor that was unsprinkled that there was a microscope and a Stryker supply cart that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery area exit corridor that was unsprinkled that there was a supply cart, two multi-drawer cabinets and an H tank on wheels that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor medical/surgical unit that the exit corridor had a computer on wheels that was plugged in, two blood pressure machines and two linen carts located in the hall near patients rooms 257 and 263 that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

EP 31

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor Geri Psych unit that the day room needed an exit sign over the second exit door. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2-West Psych unit that there were four (4) exit signs needed over the control doors in the corridor to identify the exit path. This was verified by the Director of Plant Operations.

Chapter:	Life Safety		

Supplemental #1

March 27, 2018 11:42 am

Program:

Hospital Accreditation

Standard:

LS.02.01.30

Standard Text:

The hospital provides and maintains building features to protect individuals from the

hazards of fire and smoke.

Element(s) of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable. Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 11

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

§482.41(b)(5) - (A-0712) - (5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospitals.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that the door to the Surgery decontamination room that opened to the exit corridor did not latch and was equipped with a door closer. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. I 3000 Getwell Road, Memphis, TN (Main) (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery area that the unsprinkled corridor door to Pre-op holding removed and had been fitted with a self closer and door latch. The door on to PACU on the opposite side of the hall still retained its door with self closer and door latch. This was verified by the Director of Plant Operations.

Supplemental #1 March 27, 2018 11:42 am

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.34

Standard Text:

The hospital provides and maintains fire alarm systems.

Element(s) of Performance:

2. The master fire alarm control panel is located in a protected environment (an area enclosed with 1-hour fire-rated walls and 3/4-hour fire-rated doors) that is continuously occupied or in an area with a smoke detector. (See also LS.02.01.10, EP 5) (For full text and any exceptions, refer to NFPA 101-2000: 9.6.4 and NFPA 72-1999: 1-5.6 and 3-8.4.1.3.3)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 2

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/lbr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that the Edwards fire panel was located behind the main desk area which was open to the lobby and did not have a smoke detector protecting it. This was verified by the Director of Plant Operations.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.35

Standard Text:

The hospital provides and maintains systems for extinguishing fires.

The Joint Qqmmission

Supplemental #1

March 27, 2018 11:42 am

Element(s) of Performance:

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 5

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the front lobby area that there were two dirty sprinkler heads in front of the main desk. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the front meeting that there were two dirty sprinkler heads above the front window. This was verified by the Director of Plant Operations.

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.01.01.01

Standard Text:

Medical staff bylaws address self-governance and accountability to the governing

body.

The Joint2Qommission

Supplemental #1

March 27, 2018 11:42 am

Element(s) of Performance:

3. Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the 'Leadership' (LD) chapter for requirements regarding the governing body's authority and conflict management processes.) Note: If an organization is found to be out of compliance with this Element of Performance, the citation will occur at the appropriate Element(s) of Performance 12 through 36.

Scoring Category: A

Score:

Insufficient Compliance

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6-11.) Note 1: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: The requirements referred to in this element of performance are, at a minimum, those described In the element of performance and Standard PC.01.02.03, EPs 4 and 5.

Scoring Category: A

Score:

Insufficient Compliance





March 27, 2018 11:42 am

Observation(s):

EP3

§482.12(a)(4) - (A-0048) - [The governing body must:]

(4) Approve medical staff bylaws and other medical staff rules and regulations;

This Standard is NOT MET as evidenced by:

Observed in Regulatory Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

In review of medical staff bylaws it was noted that compliance with element of performance 16 in this standard was not met because the process for completing and documenting medical history and physical examinations was not described in sufficient detail to satisfy CoP 482.22 (c) (5) (i) - (A-0358)

EP 16

§482.22(c)(5)(i) - (A-0358) - (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

This Standard is NOT MET as evidenced by:

Observed in Regulatory Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

The requirements for completing and documenting medical history and physical examination were not described in detail sufficient to specify exactly who may perform H&P's and required updates, the time frames involved, and the requirement for countersignature when applicable. The statement relating to H&P in the Bylaws simply referenced the related section in the medical staff Rules and Regulations.

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.03.01.01

Standard Text:

The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

Element(s) of Performance:

2. Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

Supplemental #1 March 27, 2018 11:42 am

EP 2

§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members. This Standard is NOT MET as evidenced by:

Observed in Record Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

The record of a patient who had undergone an operation by a podiatric surgeon under general anesthesia was reviewed. The record contained a preoperative H&P that had been documented by the podiatrist. During the credentialing session, it was confirmed that podiatrists at this hospital did not have privileges to perform H&Ps. In providing this service to this patient, this podiatrist was practicing outside the scope of his privileges as determined by the organized medical staff. The podiatrist was appropriately licensed and had been credentialed and privileged by the medical staff to perform the surgical procedure.

Observed in Record Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

On review of a second record of a patient who presented for a podiatric surgical procedure under anesthesia, it was noted that the H&P had been performed and documented by a nurse anesthetist. On review of the credentials file of a nurse anesthetist, it was noted that the specific privilege of performing general medical histories and physical examinations had not been granted to nurse anesthetists. The anesthetist had been granted specific privileges for performing examinations necessary to determine preanesthesia risk assessments, but not for a full medical H&P that would count as an admission H&P for other medical purposes. In performing the complete admission H&P for this podiatric patient, the anesthetist was practicing outside the scope of his privileges as determined by the medical staff.

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.08.01.03

Standard Text:

Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing

privilege prior to or at the time of renewal.

Element(s) of Performance:

2. The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the organized medical staff.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

Supplemental #1
March 27, 2018
11:42 am

EP 2

§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members. This Standard is NOT MET as evidenced by:

Observed in Medical Management Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for

the Hospital deemed service.

During tracer activity, record review, and subsequent discussion with medical staff members at the credentialing and privileging session, it was learned that a nurse anesthetist was independently performing pain management procedures utilizing lumbar epidural steroid injections. On review of the credentials file for this anesthetist, there was no documentation of a request from the anesthetist to perform this specific procedure, a procedure which was outside the scope of the privileges originally granted to him. The medical staff and anesthesia department had not proactively developed a process for monitoring this procedure by an anesthetist and had not determined the type of data to be collected for assessment. At the time of his most recent reappointment, there was no notation of the number of procedures he had done or the outcomes from the interventions during the pervious appointment cycle. This was the only anesthetist at the hospital performing lumbar epidural steroid injections.

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.03.01.01

Standard Text:

The hospital safely stores medications.

Element(s) of Performance:

 The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Note: This element of performance is also applicable to sample medications.

Scoring Category: C

Score:

Partial Compliance

Observation(s):

ESC 60 days



The Joint 20mmission

Supplemental #1
March 27, 2018
11:42 am

EP 2

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. During tracer activity on the Med-Surg unit it was noted that the documentation for the temperature in the medication refrigerator attached to the automated dispensing system was missing for November 29th. Hospital policy required daily documentation of refrigerator temperature to assure consistency of function.

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. Senior care unit: Temperatures were not continuously monitored in the dormitory style refrigerator that stored a box of influenza vaccines. Staff checked the refrigerator temperature once daily. The refrigerator was also observed to have a large amount of frost and ice formation.

Chapter:

Performance Improvement

Program:

Hospital Accreditation

Standard:

PI.02.01.01

Standard Text:

The hospital compiles and analyzes data.

Element(s) of Performance:

4. The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

A

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 4

§482.21 - (A-0263) - §482.21 Condition of Participation: Condition of Participation: Quality Assessment and Performance Improvement Program

This Standard is NOT MET as evidenced by:

Observed in Data Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

While the hospital collected a large amount of data, there was no data analysis performed over time to identify variance in performance. There was a lack of evidence the hospital aggregated, analyzed, and compared internal data to identify patterns, trends, and variations over time. The hospital provided lists and spreadsheets of raw data including falls; restraints; elopement; harm to staff and patients; and hand hygiene compliance.

Chapter:

Provision of Care, Treatment, and Services

Supplemental #1
March 27, 2018
11:42 am

Program:

Hospital Accreditation

Standard:

PC.01.02.08

Standard Text:

The hospital assesses and manages the patient's risks for falls.

Element(s) of Performance:

1. The hospital assesses the patient's risk for falls based on the patient population and setting.

1

Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. Senior Care unit: An initial assessment to determine the patient's risk for falls was not documented as required by the organization's policy #NSG 02-42: "Fall precaution assessment and rating". The patient was admitted to the hospital 11/18 but the first documented assessment for risk for falls was entered at 1916 on 11/19.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. An initial assessment to determine the patient's risk for falls was not documented as required by the organization's policy #NSG 02-42: "Fall precaution assessment and rating". The patient was admitted to the hospital 11/21 at 0630 but the first documented assessment for risk for falls was entered 11/22 at 1617.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.13

Standard Text: The hospital assesses the needs of patients who receive treatment for emotional

and behavioral disorders.

The Joint266mmission

Supplemental #1
March 27, 2018
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Element(s) of Performance:

- 2. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:
- Current mental, emotional, and behavioral functioning
- Maladaptive or other behaviors that create a risk to the patient or others
- Mental status examination
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient's care
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient's illness and circumstances leading to admission
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan (See also PC.01.03.01, EP 1)

Scoring Category: A

Score: Insufficient Compliance

Observation(s):

EP 2

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

For a patient's initial multidisciplinary treatment plan, there was a lack of a psychiatrist's signature by name and title. The organization's policy #BH 02-09: "Treatment planning" required those participating in the development of the treatment plan to sign the plan by name and title. (Note: This was obtained as a late entry on the last day of survey activities.)

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.11

Standard Text: Resuscitation services are available throughout the hospital.

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Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 2

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. Senior care unit: On 12/1/2015, the time of day displayed/printed on the defibrillator/monitor on the emergency resuscitation cart was incorrect. The time displayed/printed was 1605 but the actual time of day was 1430. The unit director reported the defibrillator/monitor tape was retained for documentation in the patient's medical record. (The time of day was observed to be corrected on site 12/2.)

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.04.01.05

Standard Text:

Before the hospital discharges or transfers a patient, it informs and educates the

patient about his or her follow-up care, treatment, and services.

Element(s) of Performance:

8. The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand. (See also RI.01.01.03, EP 1)

Scoring Category: C

Score:

Partial Compliance

Observation(s):



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EP8

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For a patient that received procedural sedation (ketamine and propofol) in the ED, the written discharge instructions lacked instructions specific to the sedation received.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For a patient that received procedural sedation (versed) in the ED, the written discharge instructions lacked instructions specific to the sedation received.

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.01.01.01

Standard Text:

The hospital maintains complete and accurate medical records for each individual

patient.

Element(s) of Performance:

 For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed. A

Scoring Category : C

Score:

Partial Compliance

Observation(s):

EP 19

§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

The record of a patient who underwent placement of a dialysis catheter under anesthesia was reviewed. The surgeon had not dated or timed his authentication mark on the document for informed consent.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

The practitioner's pre-procedural ECT orders and post-procedural ECT note lacked documentation of date and/or time.

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Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.02.01.11

Standard Text:

The organization screens all individuals served for their nutritional status.

Note: Triggers for a nutritional assessment may include a weight loss or weight gain

of 10 pounds or more in the past three months, a change in appetite, dental problems, noncompliance with a special diet, and food allergies. (Refer to

CTS.02.03.09, EP 1 for more information)

Element(s) of Performance:

 The organization screens all individuals served to identify those for whom a nutritional assessment is indicated.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. There was no process to screen individuals served in the partial hospitalization process to identify those for whom a nutritional assessment was indicated. When asked, the nurse said that that this was not a part of the assessment process. This patient was not screened.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. There was no process to screen individuals served in the partial hospitalization process to identify those for whom a nutritional assessment was indicated. When asked, the nurse said that that this was not a part of the assessment process. This patient was not screened.

Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.03.01.01



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Standard Text:

The organization bases the planned care, treatment, or services on the needs,

strengths, preferences, and goals of the individual served.

Note: For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.

Element(s) of Performance:

1. The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP₁

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had several needs that were identified in the assessments and that he described in talking with him. These included finding a place to live where he could live with a roommate and returning to school to complete his education. However, they were not used in the treatment plan. The treatment plan included only the diagnoses.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had several needs that were identified in the assessments and that he described in talking with him. In particular, he was interested in developing supportive relationships and being an outstanding grandfather. However, these needs and goals were were not used in the treatment plan. The treatment plan included only the diagnoses.

Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.03.01.03

Standard Text:

The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

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Element(s) of Performance:

3. The objectives of the plan for care, treatment, or services meet the following criteria:

- They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3)

- They are sufficiently specific to assess the progress of the individual served

- They are expressed in terms that provide indices of progress

Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP3

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The objectives in the treatment plan did not include identified steps to achieve the goal and were not written in terms that were sufficiently precise to permit assessing the progress of the client.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The objectives in the treatment plan did not include identified steps to achieve the goal and were not written in terms that were sufficiently precise to permit assessing the progress of the client.

Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.04.03.33

Standard Text:

For organizations providing food services: The organization has a process for

preparing and/or distributing food and nutrition products.

Element(s) of Performance:

3. For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):



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EP 3

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The partial hospitalization program stored food and beverages used by patients in a refrigerator. There was a process to ensure that the proper temperature was maintained. However, it was ineffective. The designated temperature range was 33 to 40 degrees. The recorded temperature for 4 of the last 30 days had been out of range and no action had been taken. The current temperature on the thermometer in the refrigerator was out of range.

Chapter:

National Patient Safety Goals

Program:

Behavioral Health Care Accreditation

Standard:

NPSG.15.01.01

Standard Text:

Identify individuals at risk for suicide.

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had been admitted with recent suicidal ideation and a suicide plan. There was no suicide risk assessment that included individual factors that both increase and decrease the risk of suicide.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had been admitted with recent suicidal ideation. There was no suicide risk assessment that included individual factors that both increase and decrease the risk of suicide.

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Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program: Hospital Accreditation

Program

Standards: HR.01.04.01 EP4

HR.01.06.01 EP5

LS.02.01.30 EP2,EP23

MM.04.01.01 EP13

MM.05.01.01 EP11

NPSG.15.01.01 EP1

PI.02.01.01 EP1

RC.02.01.03 EP7

Program: Behavioral Health Care

Accreditation Program

Standards: CTS.02.02.01 EP1

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Opportunities for Improvement - Detail

Chapter:

Human Resources

Program:

Hospital Accreditation

Standard:

HR.01.04.01

Standard Text:

The hospital provides orientation to staff.

Element(s) of Performance:

4. The hospital orients staff on the following: Their specific job duties, including those related to infection prevention and control and assessing and managing pain. Completion of this orientation is documented. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7; IC.02.04.01, EP 2; RI.01.01.01, EP 8)



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

FD4

Observed in Competency Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For the infection preventionist, there was a lack of documentation of orientation specific to the role and job duties of the infection preventionist.

Chapter:

Human Resources

Program:

Hospital Accreditation

Standard:

HR.01.06.01

Standard Text:

Staff are competent to perform their responsibilities.

Element(s) of Performance:

5. Staff competence is initially assessed and documented as part of orientation.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP5

Observed in Competency Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For the infection preventionist, there was a lack of documented evidence that an initial assessment of competency was completed specific to the role of the infection preventionist.

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Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.30

Standard Text:

The hospital provides and maintains building features to protect individuals

from the hazards of fire and smoke.

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ulle and

2. All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000: 18/19.3.2.1. (See also LS.02.01.10, EP 5; LS.02.01.20, EP 18) Hazardous areas include, but are not limited, to the following: Boiler/fuel-fired heater rooms

Element(s) of Performance:

- Existing boiler/fuel-fired heater rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New boiler/fuel-fired heater rooms have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- Central/bulk laundries larger than 100 square feet
- Existing central/bulk laundries larger than 100 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laundries have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New central/bulk laundries larger than 100 square feet have sprinkler systems and have 1-hour firerated walls and 3/4-hour fire-rated doors.
 Flammable liquid storage rooms (See NFPA 30-1996:4-4.2.1 and 4-4.4.2)
- Existing flammable liquid storage rooms have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- New flammable liquid storage rooms have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- Laboratories (See NFPA 45-1996 to determine if a laboratory is a 'severe hazard' area)
- Existing laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laboratories have walls fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- Existing laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. When there is a sprinkler system, the walls are fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have sprinkler systems and have 1-hour fire-rated walls with 3/4hour fire-rated doors.
- Existing flammable gas storage rooms in laboratories have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)



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- New flammable gas storage rooms in laboratories have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99 -1999: 10-10.2.2)

Maintenance repair shops

- Existing maintenance repair shops have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with at least 3/4-hour fire-rated doors.
- New maintenance repair shops have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Piped oxygen tank supply rooms (See NFPA 99-1999: 4-3.1.1.2)

- Existing piped oxygen tank supply rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New piped oxygen tank supply rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Paint shops that are not severe hazard areas

- Existing paint shops that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New paint shops that are not severe hazard areas have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Soiled linen rooms

- Existing soiled linen rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New soiled linen rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Storage rooms

- Existing storage rooms for combustible materials larger than 50 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New storage rooms for combustible materials 50 to 100 square feet are sprinklered, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- New storage rooms for combustible materials larger than 100 square feet are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Trash collection rooms

- Existing trash collection rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices;

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or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

- New trash collection rooms are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Scoring Category: C

Score:

Satisfactory Compliance

23. Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. Doors do not have nonrated protective plates more than 48 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.5, 18/19.3.7.6, and 8.3.4.1)

Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP2

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. It was observed on the 2nd floor old ICU dialysis unit that a patient room had been converted into a hazardous storage room. The room was un-sprinkled and was approximately 160 square feet. The door was not self-closing and did not latch. There were 4 wooden pallets of cardboard boxed supplies stored there. This was verified by the Director of Plant Operations.

EP23

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. It was observed that the back door to Dietary that was in a 1 hour smoke wall and was equipped with a closer and latching hardware did not latch. This was verified by the Director of Engineering.

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.04.01.01

Standard Text:

Medication orders are clear and accurate.

Element(s) of Performance:

13. The hospital implements its policies for medication orders.

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Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

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EP13

Observed in Record Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The record of a patient who underwent a surgical procedure by a podiatrist was reviewed. In the post operative orders, the podiatrist had written "resume all pre op meds". This order was not deemed acceptable by hospital pharmacy policy.

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.05.01.01

Standard Text:

A pharmacist reviews the appropriateness of all medication orders for medications to

be dispensed in the hospital.

Element(s) of Performance:

11. After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP11

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. During tracer activity on the Med-Surg unit, the record of a patient who had undergone an orthopedic procedure the previous day was reviewed. The physician had ordered both Dilaudid and Morphine "for pain". Both orders had been reviewed by the pharmacist and were active in the MAR. The physician had not specified the pain level to prompt intervention or the sequence in which the two therapeutic options should be utilized. The questions had not been clarified with the prescriber by the pharmacist before entering the orders into the MAR.

Chapter:

National Patient Safety Goals

Program:

Hospital Accreditation

Standard:

NPSG.15.01.01

Standard Text:

Identify patients at risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being

treated for emotional or behavioral disorders in general hospitals.

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

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EP1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For a patient admitted to the Dual Diagnosis unit, the patient's risk for suicide was not accurately assessed as required by the organization's policy. The patient's risk was scored 17 (defined by the organization as low risk) but not accurately documented as 27 (defined by the organization as moderate risk). The organization's policy #02-38: Suicide risk assessment" required staff to complete the initial suicide risk assessment as part of the initial admission assessment.

Chapter:

Performance Improvement

Program:

Hospital Accreditation

Standard:

PI.02.01.01

Standard Text:

The hospital compiles and analyzes data.

Element(s) of Performance:

1. The hospital compiles data in usable formats.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP1

Observed in Data Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.

There was a lack of evidence the hospital compiled data in usable formats. Data such as; falls, restraints, elopement, episodes of harm to staff and patients, and hand hygiene compilance were presented as raw data in lists and spreadsheets.

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.02.01.03

Standard Text:

The patient's medical record documents operative or other high-risk procedures and

the use of moderate or deep sedation or anesthesia.

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Element(s) of Performance:

7. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

1

Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP7

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.

During tracer activity on the Med-Surg unit, the record of a patient who had undergone an orthopedic operation the previous day was reviewed. No documentation of an immediate post procedure progress note could be located. A full operative note had been dictated by the surgeon later in the day and subsequently transcribed that evening. However, there was no concurrent note in the record to provide information which may have been required by caregivers during that time interval.

Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.02.02.01

Standard Text:

The organization collects assessment data on each individual served.

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Element(s) of Performance:

- 1. As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served:
- Environment and living situation(s)
- Leisure and recreational interests
- Religion or spiritual orientation
- Cultural preferences
- Childhood history
- Military service history, if applicable
- Financial issues
- Usual social, peer-group, and environmental setting(s)
- Language preference and language(s) spoken
- Ability to self-care
- Family circumstances, including bereavement
- Current and past trauma
- Community resources accessed by the individual served

Note 1: Relevance to care, treatment, or services may be determined by the individual's presenting needs and the organization's scope of care, treatment, or services.

Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities and children and youth. Community resources for these groups encompass a wide range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking, or retail stores). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.

Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. There was a process for completing a psychosocial assessment. However, for these patient, it was not followed. A very brief assessment had been done with only a few items. The person who completed the assessment stated that when a patient is transferred from another hospital, as this patient was, this is the policy. When asked for the policy, it could not be found. There was no completed psychosocial assessment of updated psychosocial assessment for this patient.

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Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

No

Number of PFIs: 1

Site: DMC - Memphis, Inc.

Building Name: Delta Medical Center_HAP

PFIId: DMC1501

Description:

Sprinkler piping supporting other items

ILSM Access:

Projected Completion Date: 12/10/2016

Funds Committed:

Accepted Date: 12/3/2015



Official Accreditation Report

TrustPoint Hospital LLC 1009 N. Thompson Ln. Murfreesboro, TN 37129

Organization Identification Number: 528362

Unannounced Full Event: 9/9/2015 - 9/10/2015

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Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

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Executive Summary

Program(s)
Hospital Accreditation

Survey Date(s) 09/09/2015-09/10/2015

Hospital Accreditation:

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Organization Identification Number: 528362

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Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:

Hospital Accreditation

Program

Standards:

EC.04.01.01

EP15

PC.02.01.11

EP2

RI.01.03.01

EP9

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:

Hospital Accreditation

Program

Standards:

EC.01.01.01

EC.02.03.05

EP13,EP18,EP20

EC.04.01.03

EP3

EP3

EM.02.02.11

EP3

EM.03.01.01

EP2,EP4

LD.04.01.05

EP4

LD.04.04.01

EP25

MS.08.01.03

EP3

PC.01.02.03

EP5

RC.01.02.01

EP4

The Joint200mmission Summary of CMS Findings

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CoP:

§482.13

Tag: A-0115

Deficiency: Standard

Corresponds to: HAP

Text:

§482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(b)(2)	A-0131	HAP - RI.01.03.01/EP9	Standard

CoP:

§482.24

Tag: A-0431

Deficiency: Standard

Corresponds to: HAP

Text:

§482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated

or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(2)	A-0450	HAP - RC.01.02.01/EP4	Standard

CoP:

§482.41

Tag: A-0700

Deficiency: Standard

Corresponds to: HAP

Text:

§482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)		HAP - EC.02.03.05/EP13, EP18, EP20, EC.04.01.01/EP15	Standard
§482.41(a)		HAP - EC.01.01.01/EP3, EM.02.02.11/EP3	Standard

CoP:

§482.51

Tag: A-0940

Deficiency: Standard

Corresponds to: HAP

Text:

§482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)(1)(i)	A-0952	HAP - PC.01.02.03/EP5	Standard

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CoP:

Text:

§482.22

Tag: A-0338

Deficiency: Standard

Corresponds to: HAP

§482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical

care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.08.01.03/EP3	Standard

Requirements for Improvement – Detail

Chapter:

Emergency Management

Program:

Hospital Accreditation

Standard:

EM.02.02.11

Standard Text:

As part of its Emergency Operations Plan, the hospital prepares for how it will

manage patients during emergencies.

Element(s) of Performance:

3. The Emergency Operations Plan describes the following: How the hospital will evacuate (from one section or floor to another within the building, or, completely outside the building) when the environment cannot support care, treatment, and services. (See also EM.02.02.03, EPs 9 and 10)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP3

§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

The hospitals EOP and it's Fire plan does not address how the hospital will evacuate to the outside of the building when the environment cannot support care, treatment, and services.

Chapter:

Emergency Management

Program:

Hospital Accreditation

Standard:

Standard Text:

EM.03.01.01

The hospital evaluates the effectiveness of its emergency management planning

activities.

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Element(s) of Performance:

2. The hospital conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.



Scoring Category: A

Score:

Insufficient Compliance

4. The annual emergency management planning reviews are forwarded to senior hospital leadership for review. (See also LD.04.04.01, EP 25)

Note: Senior hospital leadership refers to those leaders with responsibility for organizationwide strategic planning and budgets (vice presidents and officers). The hospital may determine that all senior hospital leaders participate in reviewing emergency management reviews, or it may designate specific senior hospital leaders to review this information.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 2

Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.

For 2014 and the first 8 months of 2015 - The hospital has not conducted an annual review of the objectives and scope of its Emergency Operations Plan

EP 4

Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.

For 2014 and the first 8 months of 2015 - The hospital has not conducted an annual review of the objectives and scope of its Emergency Operations Plan. Therefore the annual emergency management planning review has not been forwarded to senior hospital leadership for review.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.01.01.01

Standard Text:

The hospital plans activities to minimize risks in the environment of care.

Note: One or more persons can be assigned to manage risks associated with the

management plans described in this standard.

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Element(s) of Performance:

3. The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. (See also EC.04.01.01, EP 15)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP3

§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the Safety Management Plan (Policy 15.053) presented to this surveyor, the plan appears to be directly copied from another Hospital and is not accurate for this hospital.. Example -The Safety Management Plan is dated "reviewed in 12/10/2010" - However this hospital did not open till 2012.

Also in section B-1-e,f,and g the Safety Plan discusses activities to be done by a Texas regulatory authorities. Note, This hospital is located in Murfreesboro TN

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.03.05

Standard Text:

The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance,

testing, and inspection requirements apply.

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Element(s) of Performance:

13. Every 6 months, the hospital inspects any automatic fire-extinguishing systems in a kitchen. The completion dates of the inspections are documented.

Note 1: Discharge of the fire-extinguishing systems is not required.

Note 2: For additional guidance on performing inspections, see NFPA 96, 1998 edition.

Scoring Category: A

Score:

Insufficient Compliance

18. The hospital operates fire and smoke dampers 1 year after installation and then at least every 6 years to verify that they fully close. The completion date of the tests is documented.

Note 1: The initial test that must occur 1 year after installation applies only to dampers installed on and after January 1, 2008.

Note 2: For additional guidance, see NFPA 80 Standard for Fire Doors and Other Opening Protectives, 2007 edition (Section 19.4.1.1) and NFPA 105, 2007 edition (Section 6.5.2).

Scoring Category: C

Score:

Partial Compliance

20. Every 12 months, the hospital tests sliding and rolling fire doors for proper operation and full closure. The completion date of the tests is documented.

Note: For additional guidance on performing tests, see NFPA 80, 1999 edition (Section 15-2.4).

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

1





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EP 13

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

For 2014 and 2015 - The hospital's documentation indicates that the kitchen hood extinguishment system was tested on 4/15, 7/14 and 4/14, which is 3 months and 9 months apart, not every 6 months as required by the standard.

EP 18

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

For the 1st floor - The hospital had it's initial (new installation) fire damper inspection during 7/2012. The hospital does not have documentation that it conducted a 1 year after installation, fire and smoke damper test and inspection.

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

For the 2nd floor - The hospital had it's initial (new installation) fire damper inspection during 7/2012. The hospital does not have documentation that it conducted a 1 year after installation, fire and smoke damper test and inspection.

EP 20

\$482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

For 2013 and 2014 - The hospital does not have documentation that annually it has conducted a test and inspection of it's 2 rolling fire doors. (dish room and loading dock)

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.04.01.01

Standard Text: The hospital collects information to monitor conditions in the environment.

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Element(s) of Performance:

15. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. (See also EC.01.01.01, EPs 3-8; EC.04.01.03, EP 1)

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

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EP 15

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - The Security Management plan review section "Security Management Plan Includes" discussed information from 2012 and activities to be implemented in 2013. There is no information for 2014 in this section.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - The Security Management Plan review section "Traffic Control" discusses Controlling access to the ER, OR, Peds. and Nursery. This hospital does not have these departments.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - The Hazardous Materials Plan review section "Hazardous Materials inventory" discusses actions related to a MSDS program to be implemented and evaluated in 2013. There is no information or data for 2014.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - Utility Management Plan review section "Emergency Generator Testing" The review states the generator was tested under "50% full connected load each month". However during the review of the generator test records earlier in the survey with the hospital's engineer, it was noted that the generator does not always meet 30% load and therefore the hospital must do an annual load bank test.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - Under the review section "Miscellaneous" the review discusses the 2012 and 2013 PII actions but there is no information related to a 2014 PII project.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.04.01.03

Standard Text:

The hospital analyzes identified environment of care issues.

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Element(s) of Performance:

3. Annually, representatives from clinical, administrative, and support services recommend one or more priorities for improving the environment of care.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP3

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - The review discusses 2012 and 2013 Pil actives but there is no information or data related to clinical, administrative, and support services recommending one or more priorities for improving the environment of care during 2014 or for PII activities to be conducted during 2015.

Chapter:

Leadership

Program:

Hospital Accreditation

Standard:

LD.04.01.05

Standard Text:

The hospital effectively manages its programs, services, sites, or departments.

Element(s) of Performance:

4. Staff are held accountable for their responsibilities.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 4

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.

Staff are not held accountable for their responsibilities, as indicated by Life Safety findings at Standard EC 02.03.05, EPs 13, 18 and 20.

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Chapter:

Leadership

Program:

Hospital Accreditation

Standard:

LD.04.04.01

Standard Text:

Leaders establish priorities for performance improvement. (Refer to the

'Performance Improvement' [PI] chapter.)

Element(s) of Performance:

25. Senior hospital leadership directs implementation of selected hospitalwide improvements in emergency management based on the following:

- Review of the annual emergency management planning reviews (See also EM.03.01.01, EP 4)
- Review of the evaluations of all emergency response exercises and all responses to actual emergencies (See also EM.03.01.03, EP 15)
- Determination of which emergency management improvements will be prioritized for implementation, recognizing that some emergency management improvements might be a lower priority and not taken up in the near term

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 25

Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.

For 2014 and the first 8 months of 2015 - The hospital has not conducted an annual review of the objectives and scope of its Emergency Operations Plan. Therefore the annual emergency management planning review has not been forwarded to senior hospital leadership for review. This prevents senior leadership from directing implementation of selected hospital wide improvements in emergency management

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.08.01.03

Standard Text:

Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing

privilege prior to or at the time of renewal.

A

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Element(s) of Performance:

3. The process for the ongoing professional practice evaluation includes the following: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 3

§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members. This Standard is NOT MET as evidenced by:

Observed in Medical Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In discussion with the medical staff office and review of physicians files, it was observed the OPPE process did not begin until April,2015. The hospital opened in 2012, therefore the reappointment process for physicians did not include OPPE data in 2014.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.03

Standard Text:

The hospital assesses and reassesses the patient and his or her condition according

to defined time frames.

Element(s) of Performance:

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

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EP 5

§482.51(b)(1)(i) - (A-0952) - (i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

Noted on the chart the anesthesia's history and physical update was not completed.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In tracer activity and review of the record, noted the anesthesia history and physical updated was not completed.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.02.01.11

ESC 45 days

Standard Text:

Resuscitation services are available throughout the hospital.

Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served.

Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 2

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN)

Noted resuscitative equipment on the medical psychiatric unit had not been checked in a manner consistent with organization policy on 9/2 and 9/4. On 9/4 a defibrillator strip was posted, but there was no documentation that the suction, oxygen tank or crash cart lock had been checked. On 9/2 there was not documentation that any of the resuscitative equipment had been checked.

Chapter:

Record of Care, Treatment, and Services

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Program:

Hospital Accreditation

Standard:

RC.01.02.01

Standard Text:

Entries in the medical record are authenticated.

Element(s) of Performance:

4. Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author.

Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date -stamped.

Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders.

Scoring Category: C

Score:

Insufficient Compliance

Observation(s):

ESC 60 days



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EP 4

§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In review of the medical record during tracer activity, progress notes by the physician were not being signed in the time frame defined by hospital policy.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In tracer activity, noted the progress notes written by the attending physician were not signed in the time frame defined by policy.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In review of the medical review ,noted the psychiatric evaluation was not signed in the time frame defined by policy.

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

During review of medical record of patient who was placed in behavioral restraints noted physician did not authenticate telephone order for restraints. Organization policy #: NUR 0012: Restraint and Seclusion, revision date 12/21/13, required the ordering physician to personally sign, time and date the telephone order within 24 hours of the time the order was originally issued.

Chapter:

Rights and Responsibilities of the Individual

Program:

Hospital Accreditation

Standard:

RI.01.03.01

Standard Text:

The hospital honors the patient's right to give or withhold informed consent.

Element(s) of Performance:

9. The informed consent process includes a discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

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EP9

§482.13(b)(2) - (A-0131) - (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In tracer activity and review if the clinical chart, noted there was not any documentation in the record that the anesthesiologist had a discussion with the patient or family members, about the risks, benefits, side effects of the proposed anesthesia treatment

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In discussion with the staff and review of the medical record on a patient who received a PICC line, there was not any documentation by the physician about the risks of the proposed treatment.

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Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	EC.02.06.01	EP1
	IC.02.02.01	EP4
	LS.02.01.10	EP5
	LS.02.01.30	EP18
	LS.02.01.35	EP4
	MM.05.01.01	EP8
	NPSG.15.01.01	EP1,EP2
	PC.01.03.01	EP23

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Opportunities for Improvement – Detail

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.06.01

Standard Text:

The hospital establishes and maintains a safe, functional environment.

Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services

appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP1

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During tracer on medical psychiatric unit noted patient identified as suicidal was housed in a non-ligature proof room. The room has an extended shower head and sink faucet in addition to a standard hospital bed and call bell cords. Patient was transferred to the adult psychiatric unit on the second floor.

Chapter:

Infection Prevention and Control

Program:

Hospital Accreditation

Standard:

IC.02.02.01

Standard Text:

The hospital reduces the risk of infections associated with medical equipment,

devices, and supplies.

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

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EP4

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site. During tracer on medical psychiatric unit noted two blood collection tubes that expired 8/15 and were stored ready for use in a mobile blood drawing tray.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.10

Standard Text:

Building and fire protection features are designed and maintained to minimize the

effects of fire, smoke, and heat.

Element(s) of Performance:

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

FP5

Observed in Building Tour at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. Main electrical room - the gap between the meeting edges of the double, 1 hour rated fire doors is over 1/8 inch.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.30

Standard Text:

The hospital provides and maintains building features to protect individuals from the

hazards of fire and smoke.

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Supplemental #1 March 27, 2018 11:42 am

Element(s) of Performance:

18. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP18

Observed in Building Tour at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site. Above the smoke doors in the hall to the Senior unit. There is an un sealed penetration in the smoke wall. Note - this was repaired during the survey.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.35

Standard Text:

The hospital provides and maintains systems for extinguishing fires.

Element(s) of Performance:

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

FP4

Observed in Building Tour at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site. Above the double smoke doors by the Private Dining room - A large bundle of IT wiring has been plastic cable tied to the sprinkler piping..

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.05.01.01

Standard Text:

A pharmacist reviews the appropriateness of all medication orders for medications to

be dispensed in the hospital.

The Joint@ommission Findings

Supplemental #1
March 27, 2018
11:42 am

Element(s) of Performance:

8. All medication orders are reviewed for the following: Therapeutic duplication.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP8

Observed in Tracer Activities at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. Noted in the medical record during tracer activity, two pain medications were ordered without clear guidelines to the nursing staff on which medication to use first.

Chapter:

National Patient Safety Goals

Program:

Hospital Accreditation

Standard:

NPSG.15.01.01

Standard Text:

Identify patients at risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being

treated for emotional or behavioral disorders in general hospitals.

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.



Scoring Category: C

Score:

Satisfactory Compliance

2. Address the patient's immediate safety needs and most appropriate setting for treatment.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

The Joint@mmission Findings

Supplemental #1 March 27, 2018 11:42 am

EP1

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During tracer on medical psychiatric unit noted risk assessment that identified specific environmental features that may increase the risk of suicide was not completed prior to or during a period in which a suicidal patient was housed on the unit. A total of 12 small and large nall clippers, and two one quart bottles of cleaning solution were stored in unlocked cabinets in an area that was not supervised 100% of the time and was easily accessible via the main hallway used by patients and anyone entering the unit.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During a tracer on the medical psychiatric unit staff were not able to verbalize a coherent plan to accomplish the every 15 minute checks required by the organization to keep a suicidal patient housed on their unit safe. A video camera was in use in the patient room, but the camera outputs were not being continuously monitored or recorded for future review.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.03.01

Standard Text:

The hospital plans the patient's care.

Element(s) of Performance:

23. The hospital revises plans and goals for care, treatment, and services based on the patient's needs. (See also RC.02.01.01, EP 2)

A

Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP23

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site. During tracer on medical psychiatric unit noted nursing care plans in 3 of 4 patient records reviewed did not reflect active medical or psychosocial issues identified during assessment.

Organization Identification Number: 528362

Page 26 of 27

The Joint Commission

Supplemental #1
March 27, 2018
11:42 am

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs:

0

Find help here Technology

ty. Tennessee, are hereby notffled that, pursuant to §40-12-105 of the Tennessee Code Annotated, relative to grand jury proceedings, it is the duty of your grand jurost to investigate any public offense which they know or have reason to believe has been committed and which is triable or indictable in this county. Any person having knowledge or proof that such an offense has been committed may apply to testify before the grand jury subject to the provisions of Tennessee Code Annotated "MO EXPERENCE NECESSARY"

(Great Opportunity)
We are in need of additional
sales people to staff our
modern facility. 5 people
needed to start work
immediately. Our current
managment came from these
positions. WE OFFER:
IN PAID COLLEGE EDICATION II
5 day work week, salary,
commission, training, life &
heath insurance, id.
vacations and management
opportunity. Apply in
person to Paul or Brian at:
WOLFCHASE CHRYSLER
BODGE JEEP
BITO Highway 64, Bartlett **AUTO SALES CAREER**

County are presently: Mrs. Mary Thomas and Mr. J.P. Vincent The forepersons in this

Memphis, Tennessee 38.103
The grand jury will next meet on Tuesday, the 20th day of March, 2018, at 9:00 A.M. in the Grand Jury Meeting Room, 201 Poplar Avenue, Memphis, Tennessee 38.103. You may be prosecuted for perjury for any oral or written statement which you make under oath to the grand jury, when you know the statement to be false, and when the statement touches on a matter material to the

Employment

Criminal Court Clerk Shelby County, Tennessee APPROVED: point in question. Richard L. DeSaussure, III Marcy Ingram County Attorney





Furniture, clothing, toys, cook-ing supplies, seasonal decor, sporting goods, camping gear, electronics, jeweiry, accessories

MOVING SALE Rain or shine this Fri. 8-2 Sat. 8-12. 1354 Auburn Woods Dr. Collierville Furniture, strollers, carseats, new in box XL Maytag W/D. clothes, h'hold

CNA Experienced CNA wants to work days or nights or 24 hour cases. CPR certified. Reasonable rates 901-357-7888

20 yrs exp. Refer. & trans. 281-4105 CAREGIVER SEEKING

WORK

RIVER OAKS MOVING/ DOWNSIZING SALE! Sat. March 10, 6406 River Tide Dr. Indoors - doors open at 7:00 am. Qutdoor furniture, jawn equip., furniture, crystal, sterling, misc. items.

Garage Sales Local treasures found here





Building Supplies

Building Supplies

CABINETS-WINDOWS CHICKASAW LUMBER

BUILDING SUPPLY

DISCOU

1260 N. HOLLYWOOD

327-1625

8-12 Sat

8-5 Mon. - Fri.

DELIVERY SERVICE

WSA

4x8 7/16" 0SB.....\$12.99 4x8 1/2" Sheetrock...\$9.95 8"x12' Tex. Siding.... \$4.95 Ceramic Tile......49¢ ft.

140 SCOTT STREET • 324-3833 **LUMBER IN STOCK**

Egan Votices MAR 10, 11 Sat 9-2 Sun @10. 1457 Sutton Meadow Ln., 38016

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rulas of the Health Services and Development Agency, that Crestwyn Behavioral Health (a behavioral health hospitall), owned and managed by Crestwyn Health Group, LLC (a limited flability company), intends to file an application for a Certificate of Need to TO APPLY FOR A CERTIFICATE OF NEED Houston Levee/Pisgan Cordova Sold House Full. Leather Sofa/ Recliners, Beds, Desk, KIT. Garage Full., Electr., GUV Clothes, Security, Sell All, No Early Sales No Bags, Must Move Your PAID items, 3% CC. Not Responsible For Acci-dents. See plos Todd's Auction Service | Upcoming-Sales aquaTreasures Estate Sales -961-488-6640 Lamar Todd

add fourteen (14) licensed beds to its facility at 9485 Crestwyn Hills Cove, Mamphis, TN 38125, at a capital cost estimated at \$100,000.

Garage Sales

Local treasures

found here

will be increased to 36 beds (increase of 3). The child/adolescent units will be increased to 32 beds (increase of 16). The dual diagnosis/substance abuse beds will be reduced from 17 beds to 12 beds (decrease of 5). All bed increases will be This project proposes to increase total licensed beds to 80 beds. The adult units in existing semi-private size patient rooms that are currently used as single rooms. The project requires no construction. The project does not contain major medical equipment or initiate or discontinue any health service.

contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsborn Road, Suite 210, Nashville, TN 37215; (615) 665-2022. Upon written request by interested parties, a local Fact-Finding public hearing The anticipated date of filing the application is on or before March 15, 2018. The shall be conducted. Written requests for hearing should be sent to the following address:

Health Services and Development Agency

Andrew Jackson Building, 9th Floor

Pursuant to TCA Sec. 68-11-1607(s)(1): (4) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency and bater than filteren (15) days beform the regularly scheduled Health Services and Development Agency meeting at while the application is originally scheduled, and (8) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

cky finds here

Browse about and be ready to grab it. Your lucky discovery is Seek and find that unexpected pot of gold.

COMMERCIALAPPEAL.COM & SATURDAY, MARCH 10, 2018 1 3D egar Notices

NOTIFICATION OF INTENT

The facility is licensed for 66 Mental Health Hospital beds by the Department of Mental Health and Substance Abuse Services. These consists of 33 adult psychiatric beds, 16 child/adolescent psychiatric beds, and 17 adult dual diagnosis/substance abuse beds.

Tennessee Health Services and Development Agency

500 Deaderick Street

\$19.95

1/2 x 4/8 Plywood...

Roof Shingles, sq...... \$34.99 90 lbs. Roll Roofing...... \$18.99

... \$15,95

4x8 Siding.....

12" x 12' Lapsiding \$6,95 ea.

Lumber, Cabinets & Doors





Supplemental #2 (Copy)

Crestwyn Behavioral Health

CN1803-018

March 28, 2018

Phillip M. Earhart, HSD Examiner Tennessee Health Services and Development Agency Andrew Jackson Building, 9th Floor 502 Deaderick Street Nashville, TN 37243

RE:

CON Application CN1803-018

Crestwyn Behavioral Health

Dear Mr. Earhart:

This letter responds to your second supplemental request for additional information on this application. The items below are numbered to correspond to your questions.

1. Section B, Need, Item 3 Incidence and Prevalence (Psychiatric Inpatient Services-Service Specific Criteria-) Page 24

Your response to this item is noted. Using the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) web-site, please compare the prevalence of serious mental illness in Shelby County to the other 6 regions in the state.

The table below compares the Regional rates of mental health hospital admissions to TDMHSAS hospitals and hospitals with whom the Department contracts. The table compares all seven TDMHSAS Planning and Policy Regions with one another and with the State rate. Although it does not cover admissions to private facilities, who outnumber TDMHSAS facilities, it does provide a perspective of serious mental illness across the State and in the project service area, insofar as that impacts State facilities. Shelby County had an admission rate of 2.1 per 1,000 adult population in FY2016. That was below the State average of 2.3. and lower than 5 out of the other 6 regions. Attached after this page is the Department's county-level detail, from which this table on this page is taken.

Inpatient Psychiatric Admissions I to TDMHSAS Affiliate Adults 18+ Years	ed Facilities	opulation								
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4-Upper Middle Tennessee	3.2	3.3	3.3							
5-Southern Middle Tennessee	1.7	1.7	1.7							
6-West Tennessee (Excluding Shelby County)	1.7	1.8	2.6							
7-Shelby County	2.2	2.1	2.1							
State of Tennessee	2.2	2.4	2.3							

Contact: Karen Edwards, Ph.D., Research Digectoral School School

County and Region Services Data Book 2017 Tennessee Behavioral Health

September 2017

Division of Planning, Research and Forensics Xinqing Deng, MD, MPH and Rachel L. Jones Office of Research Prepared by:

Substance Abuse Services Department of Mental Health &

Department of Mental Health & Substance Abuse Services

..... 1 000 Table 43. Number of admissions and rate

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Top 25% Bottom 25% 8 Data source: TDMHSAS-funded admissions to mental health services in regional mental health institutes and private psychiatric hospitals that contract with TDMHSAS: Division of Hospital Services.

N/A includes admissions from individuals "out of state" or where the county of residence was unknown or not collected.

Data note: <5 = number of admissions less than 5 but greater than or equal to 1; 0 events reported if applicable; *Rates not reported for admissions <20; PPR=TDMHSAS Planning and Policy Region.

2017 Behavioral Health

Xinging Deng, Rachel L. Jones

September 2017

supplemental #2 Morch 29,2018 11:59 A.M.

Page Two March 29, 2018

2. Section B, Need, Item 9. Relationship to Existing Similar Services (Psychiatric Inpatient Services-Service Specific Criteria-) Page 27

It is understood that occupancy data by age category cannot be computed utilizing the JAR; however utilization trends can be provided by age category by using patient days. Please provide this information for years 2014 to 2016, including a % change column '14-'16 and a total row for all the hospitals providing inpatient psychiatric services in the primary and secondary service areas.

Attached following this page is a new table showing the increase in psychiatric patient days at all area providers, from 2014 through 2016. The entire service area has increased 14.9% in this two-year period. The PSA, which provides 70.7% of all patient days, increased 13.1% while the SSA, composed of rural providers across West Tennessee increased 19.5%. The applicant wishes to withdraw the table of patient days sent in the first supplemental response, so that this is the one with the pertinent data you wish to see,.

3. Section B, Need, Item 12. Institution for Mental Disease Classification (Psychiatric Inpatient Services-Service Specific Criteria-) Page 29

Your response to this item is noted. Do adult chemical dependency beds count toward the IMD calculation?

Yes, they do, according to the Chief Financial Officer of Crestwyn.

4. Section B, Economic Feasibility, Item 6.C. Page 60

Your response to this item is noted. Please explain the difference between the financial statements in the supplemental response where long term debt is listed as \$15,827,658 and Net Assets as \$11,668,504 in 2017 versus the financial statement in the original application that identifies \$3,353,004,000 in long term debt and total equity of \$2,167,724,000 for 2016. The capitalization ratio should be for the entity funding the proposed project.

Crestwyn Behavioral Health is funding the project. Its CFO supplied a letter affirming that, in the original application. The original application included Crestwyn's income statement; but through an oversight Crestwyn's balance sheet was omitted.

Sen	Service Area Utilization Trends in	a Utilizat	ion Tren	4	ychia	tric Inp	atient	Days2	sychiatric Inpatient Days2014-2016 (New Supplemental Table / Schedule H Data	N) 9	lew Sup	plemen	Ital Tabl	le / Sche	3dule H	Data)			
		2014	14	100	196		2015	10		104		2016	9		ď	ercent C	Shange	Percent Change 2014 to 2016	2016
	0-17	18-64	+59	Total	-0 膿	0-17 18	18-64	+59	Total		0-17	18-64	+99	Total	0	0-17	18-64	65+	Total
Primary Svc Area - Shelby Co.				136	隆	-	-								10.				
Lakeside Behav Hith	13,794	40,847	7,785	62,426日		0	0	0	0		15,916	52,062	10,195	78,173		15.4%	27.5%	31.0%	25.2%
Memphis MH Institute	7	16,259	611	16,877		0	16,764	535	17,299 國		0	17,089	476	17,565 國		-100.0%	5.1%	-22.1%	4.1%
Delta MC	0	26,481	10,660	37,501	製	0 2	27,855	8,886	36,741 羅		0	25,871	7,877	33,748		%0.0	-2.3%	-26.1%	-10.0%
Methodist Univ Healthcare	0	7,921	546	8,467 職	STORY OF THE PERSON NAMED IN	0	7,046	745	7,791階	趣	0	6,295	1,041	7,336 選問		%0.0	-20.5%	%2.06	-13.4%
Saint Francis Hosp	6,359	2,796	2,347	11,502 編		6,500	3,938	3,387	13,825		4,994	3,836	2,960	11,790谜	胸	-21.5%	37.2%	26.1%	2.5%
Crestwyn Behavioral Health	0	0	0	到 0	70	0	0	0	0 0	1	232	4,982	890	6,104	700	%0.0	%0:0	%0.0	%0.0
PSA Total	20,160	94,304	21,949	136,773	9	6,500 5	55,603	13,553	75,656	Village of the last of the las	21,142	110,135	23,439	154,716	190	4.9%	16.8%	%8.9	13.1%
			10 A C				10 Sept 20 Sep			100		X SOL		State of the state			200	No. State	2 No. 10 No.
Secondary Svc Area - Other				ym:	(3)					100					100				
Baptist Mem Hosp-Huntingdon	0	0	0	0		0	105	1,766	1,871區	麗	0	137	1,300	1,437 職	摩				
Western MH Institute	0	42,182	1,301	43,483		0 4	45,255	1,600	46,855		0	47,719	2,385	50,104		%0.0	13.1%	83.3%	15.2%
Henry County Med Center	0	1,126	1,063	2,189		0	1,418	629	2,097	200	0	1,698	559	2,257 職	定	%0.0	20.8%	-47.4%	3.1%
Pathways of TN Behav Hith Svcs	0	3,645	61	3,706[極	1	0	3,160	85	3,245	500	0	3,250	52	3,304	400	%0.0	-10.8%	-11.5%	-10.8%
Woodridge, dba Oak Hills, BH	0	0	0	0		0	168	756	924		0	512	2,963	3,475		1	1		- I
Behavioral Hithcare Cntr - Martin		74	4,200	4,274 職	24	0	134	3,321	3,455		0	298	3,259	3,557 蘇斯	1000	%0.0	302.7%	-22.4%	-16.8%
SSA Total	0	47,027	6,625	53,652	(catholic	0 5	50,240	8,207	58,447	Will Company	0	53,614	10,520	64,134		%0.0	14.0%	28.8%	19.5%
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Service Area Total		20,160 141,331	28,574	190,425	9	6,500 105,843	5,843	21,760	21,760 134,103	180	21,142	163,749	33,959	218,850	980	4.9%	15.9%	18.8%	14.9%
Sources: 2015-2015 JAR Schedule H. nage 32 (25 also), 2016 JAR nage 38. Substance abuse days not included	_ nage 32 (2	3 also), 20	16 JAR na	oe 38 Sub	stance	shire days	a not incl.	ided											

Page Three March 29, 2018

Our first supplemental response corrected the omission by providing the Crestwyn balance sheet, and provided what we believe to be the correct capitalization ratio calculation, based on that balance sheet.

The parent company Acadia's financial statements--with the much larger debt and equity amounts you cite--were submitted in the original application only as a matter of information.

5. Section B, Orderly Development, Item 1 (Transfer Agreements), Page 66

Your response that this information is being gathered for submittal under separate cover is noted.

The three Acadia hospitals' accreditation surveys were provided in the last supplemental information filing. With respect to their surveys, the following information is available.

- 1. Crestwyn--This is a very new, TDMHSAS-licensed hospital that opened in Spring of 2016. Management says that they have not had a facility survey from TDMHSAS. The West Tennessee office of TDMHSAS did not have a record of one in their computer system yesterday, but is expected to perform a survey early in this calendar year.
- 2. TrustPoint in Rutherford County--This is licensed by the Department of Health because it still has rehabilitation beds, although most of its capacity is psychiatric. Dr. Jeff Woods, CEO, advises that Trustpoint has not had a TDH facility-wide survey and plan of correction; his Joint Commission surveys include a physical facility survey that is deemed sufficient by the Department of Health. However, he has provided an incident survey report from 2017, and a construction site survey, attached after this page.
- 3. Delta Medical Center, like Trustpoint, is licensed by the Department of Health. Its latest survey is attached after this page.

11:59 A.M.



February 6, 2018:

Mr. Jeffery Woods, Administrator Trustpoint Hospital 1009 North Thompson Ln Murfreesboro TN 37129

RE: TNP531184

Dear Mr. Woods:

The East Tennessee Regional Office of Health Care Facilities conducted a Life Safety construction visit on November 29, 2017. A desk review was conducted, based on that review; we are accepting your plan of correction and are assuming that your facility is in compliance with all regulations cited as of December 12, 2017.

If you have any questions, please contact this office at (865) 594-9396 or by facsimile at (865) 594-5739.

Sincerely,

7amra 7urberville/cw

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manager

TT:cw



January 26, 2017

Mr. Jeffery Woods, Administrator Trustpoint Hospital 1009 North Thompson Ln Murfreesboro TN 37129

RE: 44-0231

Dear Mr. Woods:

The East Tennessee Regional Office conducted a complaint investigation at your facility on January 17 - 19, 2017. As a result of the investigation, no deficient practice was found.

If our office may be of assistance to you, please feel free to call (865) 594-9396.

Sincerely,

Tamra Turberville cw

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manager

TT: cw

TN00038422, TN00038766, TN00038861, TN00039089, TN00040195, TN00040247

Supplemental FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES 303 CENTERS FOR MEDICARE & MEDICAID SERVICES March 29, 2019MB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION 11:59 A.M. STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 440231 **B. WING** 01/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1009 NORTH THOMPSON LANE TRUSTPOINT HOSPITAL **MURFREESBORO, TN 37129** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 000 INITIAL COMMENTS A 000 During investigation of complaint #38422. #38766, #38861, #39089, #40195, and #40247 completed 1/17/17 to 1/19/17 no deficiencies were cited related to the complaint under 42 CFR PART 483, Requirements for Hospitals.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Supplemental FORM APPROVED

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Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Supplemental #2 March 29, 2018 11:59 A.M.

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Page Four March 29, 2018

6. Section B, Quality Measures

Your response to this item is noted; however Items (3) (d)-(e) and (3)(p) 1.-3. can be applied to the existing facility. Please provide a response to each of these items and any other items that have already been met by the existing facility.

Following are the requested responses to these items:

Please verify and acknowledge the applicant will be evaluated annually whether the proposal will provide health care that meets appropriate quality standards upon the following factors:

- (3) Quality. Whether the proposal will provide health care that meets appropriate quality standards may be evaluated upon the following factors:
- (d) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

Crestwyn Behavioral Health has maintained compliance with all applicable federal and state regulation since its opening in 2015.

(e) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

Crestwyn Behavioral Health has never been decertified.

(p) For Inpatient Psychiatric projects:

1. Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;

Page Five March 29, 2018

Crestwyn meets or exceeds all State licensure standards and national accreditation standards for these aspects of its patient care. Patients with aggression issues are segregated in the adult wings from those who are not. Crestwyn does not yet accept children younger than 10 years of age, and then only rarely at the request of Youth Villages and with physician approval. But any young patient needing quiet is afforded that appropriately. Each patient bedroom has its own full bath and has a bed for each occupant. Crestwyn has submitted its staffing information in the application and first supplemental response; each unit is staffed with at least two direct patient care staff (including a nurse) at all times, and one-to-one staffing is maintained for any patient at risk for harming himself or herself or others.

2. Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems; and

The response below pertains to Crestwyn Behavioral Health, but it also reflects the standard QAPI system in place at all three Acadai hospitals in Tennessee:

Quality Assurance and Performance Improvement (QAPI) is an essential and required component of the services rendered at Crestwyn Behavioral Health. QAPI is the combination of two aspects: Quality Assurance and Performance Improvement. Quality assurance is a "process of meeting quality standards and assuring that care reaches an acceptable level." Performance Improvement is "a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent problems."

When combined, QAPI proactively examines policies and procedures to ensure systematic compliance, quality care, and patient safety.

To ensure this occurs, monthly Performance Improvement ("PI") Meetings are scheduled with the CEO, CFO, Risk Manager, Director of Clinical Services, Chief Nursing Officer, Infection Control Nurse/Nurse Educator, Director of Intake, Director of Utilization Review, Director of Human Resources, Director of Plant Operations, Patient Advocate,

Page Six March 29, 2018

Pharmacist, and Director of Outpatient Services. During the meeting they review aggregation and analysis of data from the prior month, set goals and plans for improvement, and review previous goals and achievements. A copy of the outline of such a meeting is attached following this page.

Items that are included in the monthly meetings include:

- Utilization Reports (Patient days, AMA, readmission rates, etc.)
- Intake Report (Door-to-floor times and EMTALA Compliance)
- Human Resources Report (Turnover rate, Terminations, New Hires, Employee Performance Evaluations, etc.)
- Environmental Rounds (Physical safety of the building and compliance with environment of care policies).
- Risk Management (Incident reporting analysis, Seclusion and Restraint Trends)
- Facility Safety Committee Meeting (Monthly Meeting that focuses on improvement of safety of patient and employees).
- Discharge Calls (Follow-up to address questions and concerns from patients in hopes of decreasing readmission rates).
- Patient Concerns and Grievances (Analysis of the types of concerns, resolution of concerns and trends).
- Pharmacy report and recommended areas of improvement.

Crestwyn Behavioral Health strives to provide exceptional care. When incidents or grievances occur, staff communicates the information to the appropriate care team members to ensure that the incident or concern is promptly and effectively addressed and resolved. Addressing, investigating and resolving incidents and concerns is a continuous process.

Information from QAPI meetings is presented to the Medical Executive Committee (MEC) meeting that is held every other month. The Medical Director and the medical staff (physicians and psychiatrists) attend to provide insight to the rest of the clinical care teams on any areas of concern. Ideas to improve the clinical and medical care are discussed and plans are adopted. Monitoring of progress in execution of these plans is reported to QAPI and from there to the Medical Executive Committee to ensure appropriate and thorough oversight.

Crestwyn Behavioral Health Performance Improvement Committee Meeting Date

	Members Present	Members Absent	Guest
CEO			
CFO			
Risk Manager/PI			
Director of Human Resources			
Director of Plant Operations			
Chief Nursing Officer			
Director of UR			
Director of Clinical Services			
Director of HIM			
Director of Intake			
Director of Outpatient			
Patient Advocate			
Pharmacist in Charge			
Director of Business Development			
Infection Control Nurse			
Patient Advocate			

Agenda	Discussion	Recommended	Responsible Party
Call to Order			
Approval of Minutes			2 4
I. Old Business			1:59
II. New Business			h 29
III. Intake Report), 20 //.
W. Utilization Review			011
V. HBIPS Reports			B

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HR Dashboard	EOC Safety Rounds	Nursing	Infection Control	Acadia Scorecard	Seclusions and	Restraints	Incidents	Patient Satisfaction	Survey	Patient Safety	Committee Meeting	CMS Survey POC	Concerns and	Grievances	Discharge Calls	Town Hall Meetings	Adjourn	
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Supplemental # 2 March 29, 2018 11:59 A.M.

Page Seven March 29, 2018

3. Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.

The applicant has submitted its accreditation surveys from all three Acadia hospitals operating in Tennessee. In this response, the applicant has attached additional information regarding facility-wide surveys and quality improvement processes. Please see the responses above.

7. Proof of Publication

Lilellon

It appears that only copies of the proof of publication were provided. Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

Attached at the end of this letter are a copy of the newspaper's affidavit of publication, and the public notice photocopy that was appended to the affidavit. Please accept these in lieu of new originals, which can not be obtained by your deadline for submitting this response.

Thank you, Mark, for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn Consultant

The Commercial Appeal Affidavit of Publication

STATE OF TENNESSEE COUNTY OF SHELBY

Personally appeared before me, Glenn W. Edwards, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal, to-wit:

March 10, 2018

Subscribed and sworn to before me this 12th day of March, 2018

My commission expires January 20, 2020

fun than a bunny, 6 yell/white 5 females 3 males, parents on 1.5 site AKC reg. S&W, dewclaws removed: (901)826-4265

Legal Netices

CLEARL 810. 38016 Cordova SF Sofa/ Sk, KIT. GUY All, No ns. 3% or Acci-Auction iles Sales

r Todd

Legal Natices NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601; et sequent file. Rules of the Health Services and Development Agency, that Creatwyn Behavioral Health (a behavioral health hospital), owned and managed by Creatwyn Health Creaty. 11 C (a limited liability company), intends to the an application for a Health Group, LLC (a limited liability company), intends to file an application for a

add fourteen (14) licensed beds to its facility at 9485 Crestwyn Hills Cove, Memphis, Certificate of Need to: TN 38125; at a capital coat estimated at \$100,000.

The facility is licensed for 68 Montal Health Hospital beds by the Department of Mental Health and Substance Abuse Services. These consist of 33 adult psychiatric beds, 18 child/adolescent psychiatric beds, and 17 adult dual disgnosis/substance

This project proposes to increase total licensed beds to 30 beds. The addit units will be increased to 36 beds (increase of 3). The child/adolescent units will be increased to 32 beds (increase of 19). The dual diagnosis/substance abuse beds increased to 32 beds (total diagnosis/substance abuse beds increased from 17 beds to 12 beds (decrease of 5). All bed increases will be reduced from 17 beds to 12 beds (decrease of 5). All bed increases will be in existing semi-private size patient rooms that are currently used as single rooms. The project requires no construction. The project does not contain major medical equipment or initiate or discontinue any health service.

The anticipated date of filing the application is on or before Merch 15, 2018. The contact person for the project is John Wellborn, who may be reached at Development contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Sulte 210, Nashville, TN 37215, (615) 865–2022: Upon written request by Interested parties, a local Fact Finding public hearing should be conducted. Written requests for hearing should be sent to the following

Health Services and Development Agency

Tennessoe Health Services and Development Agency

Andrew Jackson Building, 9th Floor

500 Deaderick Street

Pursuant to TGA Sec. 83-11-1607(c)(1): (A) any health care institution withing to popose a Certificate of Need application must file a written objection with the health Services and Development Agency no later than fitteen (15) days before the regularly echeduled Health Services and Development Agency meeting at which the application is originally acheduled, and (3) any other person wishing to appose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.



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DOD

Supplemental #2 Morch 29,2018 11:59 A.M.

AFFIDAVIT

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY: CRESTWYN BEHAVIORAC HEACTH

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the Agus day of witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires

HF-0043

Revised 7/02

STATE OF TENNESSEE NOTARY PUBLIC A SON COUNTY

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LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Commercial Appeal, which is a newspaper of general circulation in Shelby County, Tennessee, on or before March 10, 2018, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Crestwyn Behavioral Health (a behavioral health hospital), owned and managed by Crestwyn Health Group, LLC (a limited liability company), intends to file an application for a Certificate of Need to add fourteen (14) licensed beds to its facility at 9485 Crestwyn Hills Cove, Memphis, TN 38125, at a capital cost estimated at \$100,000.

The facility is licensed for 66 Mental Health Hospital beds by the Department of Mental Health and Substance Abuse Services. These consist of 33 adult psychiatric beds, 16 child/adolescent psychiatric beds, and 17 adult dual diagnosis/substance abuse beds.

This project proposes to increase total licensed beds to 80 beds. The adult units will be increased to 36 beds (increase of 3). The child/adolescent units will be increased to 32 beds (increase of 16). The dual diagnosis/substance abuse beds will be reduced from 17 beds to 12 beds (decrease of 5). All bed increases will be in existing semi-private size patient rooms that are currently used as single rooms. The project requires no construction. The project does not contain major medical equipment or initiate or discontinue any health service.

The anticipated date of filing the application is on or before March 15, 2018. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

(Signature)

(Date)

jwdsg@comcast.net (E-mail Address)

RULES OF HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-11 CERTIFICATE OF NEED PROGRAM – GENERAL CRITERIA

TABLE OF CONTENTS

0720-11-.01 General Criteria for Certificate of Need

0720-11-.01 GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

- (1) Need. The health care needed in the area to be served may be evaluated upon the following factors:
 - (a) The relationship of the proposal to any existing applicable plans;
 - (b) The population served by the proposal;
 - (c) The existing or certified services or institutions in the area;
 - (d) The reasonableness of the service area:
 - The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;
 - (f) Comparison of utilization/occupancy trends and services offered by other area providers;
 - (g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.
- (2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:
 - (a) Whether adequate funds are available to the applicant to complete the project;
 - (b) The reasonableness of the proposed project costs:
 - (c) Anticipated revenue from the proposed project and the impact on existing patient charges;
 - (d) Participation in state/federal revenue programs;
 - (e) Alternatives considered; and
 - (f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

- (3) Quality. Whether the proposal will provide health care that meets appropriate quality standards may be evaluated upon the following factors:
 - (a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;
 - (b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;
 - (c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;
 - (d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;
 - (e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered:
 - (f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;
 - (g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.
 - This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable. Other acceptable accrediting organizations may include, but are not limited to, the following:
 - (i) Those having the same accrediting standards as the licensed hospital of which it will be a department, for a Freestanding Emergency Department;
 - (ii) Accreditation Association for Ambulatory Health Care, and where applicable, American Association for Accreditation of Ambulatory Surgical Facilities, for Ambulatory Surgical Treatment Center projects;
 - (iii) Commission on Accreditation of Rehabilitation Facilities (CARF), for Comprehensive Inpatient Rehabilitation Services and Inpatient Psychiatric projects;
 - (iv) American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority, for Megavoltage Radiation Therapy projects;
 - (v) American College of Radiology, for Positron Emission Tomography, Magnetic Resonance Imaging and Outpatient Diagnostic Center projects;

- (vi) Community Health Accreditation Program, Inc., Accreditation Commission for Health Care, or another accrediting body with deeming authority for hospice services from CMS or state licensing survey, and/or other third party quality oversight organization, for Hospice projects;
- (vii) Behavioral Health Care accreditation by the Joint Commission for Nonresidential Substitution Based Treatment Center, for Opiate Addiction projects;
- (viii) American Society of Transplantation or Scientific Registry of Transplant Recipients, for Organ Transplant projects;
- (ix) Joint Commission or another appropriate accrediting authority recognized by CMS, or other nationally recognized accrediting organization, for a Cardiac Catheterization project that is not required by law to be licensed by the Department of Health;
- (x) Participation in the National Cardiovascular Data Registry, for any Cardiac Catheterization project;
- (xi) Participation in the National Burn Repository, for Burn Unit projects:
- (xii) Community Health Accreditation Program, Inc., Accreditation Commission for Health Care, and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives, Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects; and
- (xiii) Participation in the National Palliative Care Registry, for Hospice projects.
- (h) For Ambulatory Surgical Treatment Center projects, whether the applicant has estimated the number of physicians by specialty expected to utilize the facility, developed criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel, and documented the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.
- (i) For Cardiac Catheterization projects:
 - Whether the applicant has documented a plan to monitor the quality of its cardiac catheterization program, including but not limited to, program outcomes and efficiencies;
 - Whether the applicant has agreed to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee, which may be developed per Policy Recommendation; and
 - 3. Whether the applicant will staff and maintain at least one cardiologist who has performed 75 cases annually averaged over the previous 5 years (for an adult program), and 50 cases annually averaged over the previous 5 years (for a pediatric program).
- (j) For Open Heart projects:

- 1. Whether the applicant will staff with the number of cardiac surgeons who will perform the volume of cases consistent with the State Health Plan (annual average of the previous 2 years), and whether the applicant will maintain this volume in the future;
- Whether the applicant will staff and maintain at least one surgeon with 5 years of experience;
- 3. Whether the applicant will participate in a data reporting, quality improvement, outcome monitoring, and peer review system that benchmarks outcomes based on national norms, with such a system providing for peer review among professionals practicing in facilities and programs other than the applicant hospital (demonstrated active participation in the STS National Database is expected and shall be considered evidence of meeting this standard):
- (k) For Comprehensive Inpatient Rehabilitation Services projects, whether the applicant will have a board-certified physiatrist on staff (preferred);
- (I) For Home Health projects, whether the applicant has documented its existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system;
- (m) For Hospice projects, whether the applicant has documented its existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system;
- (n) For Megavoltage Radiation Therapy projects, whether the applicant has demonstrated that it will meet the staffing and quality assurance requirements of the American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority;
- (o) For Neonatal Intensive Care Unit projects, whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system; whether the applicant has documented the intention and ability to comply with the staffing guidelines and qualifications set forth by the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities; and whether the applicant will participate in the Tennessee Initiative for Perinatal Quality Care (TIPQC);
- (p) For Nursing Home projects, whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems, including in particular details on its Quality Assurance and Performance Improvement program. As an alternative to the provision of third party accreditation information, applicants may provide information on any other state, federal, or national quality improvement initiatives;
- (q) For Inpatient Psychiatric projects:
 - Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all

- times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;
- Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system; and
- 3. Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.
- (r) For Freestanding Emergency Department projects, whether the applicant has demonstrated that it will satisfy and maintain compliance with standards in the State Health Plan;
- (s) For Organ Transplant projects, whether the applicant has demonstrated that it will satisfy and maintain compliance with standards in the State Health Plan; and
- (t) For Relocation and/or Replacement of Health Care Institution projects:
 - For hospital projects, Acute Care Bed Need Services measures are applicable; and
 - 2. For all other healthcare institutions, applicable facility and/or service specific measures are applicable.
- (u) For every CON issued on or after the effective date of this rule, reporting shall be made to the Health Services and Development Agency each year on the anniversary date of implementation of the CON, on forms prescribed by the Agency. Such reporting shall include an assessment of each applicable volume and quality standard and shall include results of any surveys or disciplinary actions by state licensing agencies, payors, CMS, and any self-assessment and external peer assessment processes in which the applicant participates or participated within the year, which are relevant to the health care institution or service authorized by the certificate of need. The existence and results of any remedial action, including any plan of correction, shall also be provided.
- (v) HSDA will notify the applicant and any applicable licensing agency if any volume or quality measure has not been met.
- (w) Within one month of notification the applicant must submit a corrective action plan and must report on the progress of the plan within one year of that submission.
- (4) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:
 - (a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);
 - (b) The positive or negative effects attributed to duplication or competition; and

- (c) The availability and accessibility of human resources required by the proposal, including consumers and related providers.
- (5) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, The Agency may consider, in addition to the foregoing factors, the following factors:
 - (a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change to the proposed new site.
 - (b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.
 - (c) Quality of Health Care to be provided. The applicant should show the quality of health care to be provided will be served at least as well as the original site.
 - (d) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.
- (6) Certificate of need conditions. In accordance with T.C.A. § 68-11-1609, The Agency, in its discretion, may place such conditions upon a certificate of need it deems appropriate and enforceable to meet the applicable criteria as defined in statute and in these rules.

Authority: T.C.A. §§ 4-5-202, 4-5-208, 68-11-1605, 68-11-1609, and 2016 Tenn. Pub. Acts Ch. 1043. Administrative History: Original rule filed August 31, 2005; effective November 14, 2005. Emergency rule filed May 31, 2017; effective through November 27, 2017.



STATE OF TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ANDREW JACKSON BUILDING, 6th FLOOR 500 DEADERICK STREET NASHVILLE, TENNESSEE 37243

GOVERNOR

MARIE WILLIAMS

COMMISSIONER

May 27, 2018

Crestwyn Behavioral Health – CN1803-018

The Department of Mental Health and Substance Abuse Services staff has reviewed the Crestwyn Behavioral Health Certificate of Need application for the addition of 14-beds to existing space within the facility. The addition of 14-beds will include the addition of 3 adult beds, the addition of 16 adolescent beds, and the removal of 5 licensed substance abuse beds. The addition and reallocation of beds will not require any new construction or renovation. Crestwyn Behavioral Health located in Memphis, TN (Shelby County), with the primary service area being Shelby County and a secondary service area consisting of Tennessee, Arkansas, and Mississippi including Benton, Benton MS, Carroll, Chester, Crittenden AR, Crockett, Decatur, Desoto MS, Dyer, Fayette, Lake, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Fayette, Lauderdale, Lawrence AR, Madison, Marshall MS, McNairy, Obion, and Tipton counties. The review focused on the need for psychiatric beds in this part of the state, plus economic feasibility, quality measures, as well as the contribution the addition of these beds could have on the orderly development of healthcare.

Scope of Project

The project overview will address the addition of 14-beds to serve adults, adolescents and individuals diagnosed with a substance abuse diagnosis. The estimated project cost is \$91,000 with projected approval occupancy of 8/27/2018. The proposed addition of 14-beds will not require new construction or renovation, but will compose of changing private rooms to a semiprivate status. The full project cost will be funded by cash reserves available to the applicant.

If the proposed addition of 14-inpatient beds is approved, Crestwyn Behavioral Health will be licensed for 80-beds. The licensed bed capacity will be achieved by adding new beds and converting existing ones as follows: the addition of 3 adult beds, increasing the total from 33 to 36; the addition of 16 adolescent beds, increasing the total from 16 to 32; and the conversion of substance abuse beds, reducing the total from 17 to 12 (a reduction of 5 beds). Crestwyn Behavioral Health accepts both voluntary and involuntary admissions.

Crestwyn Behavioral Health is owned by Acadia 60%, Baptist Memorial Hospital Health Services, Inc. 20%, and Saint Francis Hospital 20%. Crestwyn Behavioral Health is managed by Acadia, who also operates the following facilities: Delta Medical Center (Shelby County), Trustpoint Hospital (Rutherford County), and Erlanger Behavioral Health (Hamilton County).

Service Area

The project's primary service area is Shelby County. Secondary service areas in Tennessee, Arkansas, and Mississippi include: Benton, Benton MS, Carroll, Chester, Crittenden AR, Crockett, Decatur, Desoto MS, Dyer, Fayette, Lake, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Fayette, Lauderdale, Lawrence AR, Madison, Marshall MS, McNairy, Obion, and Tipton counties.

Analysis

Need

Tennessee's State Health Plan sets the population-based estimate for the total need for psychiatric inpatient services at 30 beds per 100,000 general population. The application of the formula can result in an underestimation of the number of inpatient psychiatric beds needed due to a number of factors: bed utilization, willingness of the provider to accept emergency involuntary admissions, the extent to which the provider serves the TennCare population and/or the indigent population as well as for specialty populations, depending on how the beds are distributed. Other influencing factors include the number of existing beds in the proposed service area, bed utilization and available community services.

Psychiatric Bed Need

	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current Licensed Beds	Net Need
	Child/Adolescent	Child/Adolescent	Child/Adolescent	Child/Adolescent
	0-17	0-17	0-17	0-17
Proposed Primary Service Area	252,312	76	140	-64
Proposed Secondary Service Area	148,338	45	0	45
Total	400,650	120	140	-20

	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current Licensed Beds	Net Need
	Adult & Geri	Adult & Geri	Adult & Geri	Adult & Geri
	18+	18+	18+	18+
Proposed Primary Service Area	728,710	219	604	-385
Proposed Secondary Service Area	531,674	160	278	-118
Total	1,260,384	378	882	-504

Patient Origin Data for Crestwyn (2016/2017)

County	State	Admissions	County % of All Admissions
Shelby	TN	790	59.5%
DeSoto	MS	65	4.9%
Tipton	TN	41	3.1%
Madison	TN	31	2.3%
Crittenden	TN	25	1.9%
Carroll	TN	22	1.7%
Gibson	TN	21	1.6%
Lauderdale	TN	21	1.6%
Marshall	TN	15	1.1%
Fayette	TN	11	0.8%
Knox	TN	11	0.8%
Benton	TN	10	0.8%
Davidson	TN	10	0.8%
McNairy	TN	10	0.8%
Weakley	TN	10	0.8%
Dyer	TN	9	0.7%
Hardeman	TN	9	0.7%
Rutherford	TN	9	0.7%
Henry	TN	8	0.6%
Lawrence	TN	8	0.6%
Putnam	TN	8	0.6%
Crockett	TN	7	0.5%
Henderson	TN	7	0.5%
Maury	TN	6	0.5%
Montgomery	TN	6	0.5%
Obion	TN	6	0.5%
Other	TN &	152	11.4%
	Others		
TOTAL		1,328	

Outstanding CONs Impacting Supply in Service Area

The project does not initiate or discontinue any other health service. In addition, there are no approved but unimplemented CONs for inpatient mental health services in the primary or secondary service area of the applicant.

Economic Feasibility

Ownership and Management

The applicant and license holder is Crestwyn Health Group, LLC DBA Crestwyn Behavioral Health. Crestwyn is jointly owned by three entities: Acadia Crestwyn Holdings, LLC 60%, Amisub (SFH), Inc. 20%,

and Baptist Memorial Hospital Health Services, Inc. 20%. Acadia Crestwyn Holdings, LLC, the majority member and licensee, is a wholly owned subsidiary of Acadia Healthcare. Acadia Amisub (SFH), Inc. is the local subsidiary of Saint Francis Hospital's national parent, Tenet. Baptist Memorial Health Services, Inc., is an entity of the Baptist Hospital System of Shelby County.

Expected Costs and Alternative, Revenue and Expense Information

The project appears economically feasible based upon the projection data provided. The data provided has the net revenue per patient day at \$725.00 in year one. Year two break-even revenue per patient day is \$729.00.

Applicant's Projected Payor Mix, Year 1

Applicant's projected payor mix, for year one consists of Medicare/Medicare Managed Care at 22.5%, Medicaid/TennCare at 46.3%, Commercial Insurance/Other Managed Care at 27.7%, Self-Pay at 0.8%, Charity Care at 0.9%, and Other at 1.8%.

Projections of Utilizations, Occupancy

The following chart was completed for review of projected bed utilization based upon the State Health Plan and need formula. Support for bed projections was also reviewed with local crisis providers and community providers.

	2018	Year 1	Year 2	Year 3
Crestwyn Total Beds	66	80	80	80
Admissions	2,004	2,275	2,404	2,479
Patient Days	20,043	22,749	24,022	24,737
ALOS on Admissions	10.0	10.0	10.0	10.0
% Occupancy	83.2%	77.9%	82.0%	84.7%

Considerations of Other Alternatives

In considering alternatives, the applicant stated the only option considered was to increase bed capacity due to occupancy rate. The applicant states by converting existing private rooms to semiprivate rooms it will allow the addition of 14 beds without construction or delay.

Quality Standards

Crestwyn Behavioral Health is licensed by the Tennessee Department of Mental Health and Substance Abuse Services as a 66-bed mental health hospital. In addition, Crestwyn Behavioral Health is accredited by the Joint Commission and is Medicare and Medicaid certified. Crestwyn Behavioral Health has never been decertified.

Access

The addition of 14 inpatient mental health beds will provide local accessible inpatient mental health treatment for adolescents and adults. Proposed beds will allow service access close to home, family, personal physician, outpatient service provider and other supports. Providing services to individuals in the community in which they live is a concept that TDMHSAS continues to support.

Contribution to the Orderly Development of Health Care

This project supports access to specialized healthcare for children (10 and older), adolescents and adults requiring inpatient mental health treatment. It also proposes to provide access to services to medically underserved populations, those needing involuntary emergency hospitalization, and those with TennCare. Inpatient psychiatric services are reserved for situations when the safety of the patient and/or others cannot be guaranteed in a less restrictive setting and provides an opportunity to plan for on-going community services to prevent the need for future inpatient services.

Crestwyn Behavioral Health provides post-discharge support programs including an adolescent intensive outpatient program (IOP) weekday evenings, a partial hospital program for adults on weekday mornings, an adult IOP weekday evenings, and a daytime IOP weekday mornings. Intensive outpatient programs and partial hospital programs provide an alternative to inpatient hospitalization and can reduce the risk of readmission.

Staffing/Recruitment/Salaries

The proposed staffing pattern appears to be adequate with listed salaries for position classifications being within or above local hiring practices. Additional position classifications for direct patient care include registered nurses, mental health technicians, and master's level clinicians. Crestwyn Behavioral Health currently staffs units to meet Licensure and Joint Commission requirements.

Physical Plant

The addition of 14 beds does not require new construction or renovation. Existing private rooms will be changed to a semiprivate status. Private patient rooms will be provided based upon patient need.

Effects on Existing Providers and Resources

The applicant does not anticipate any negative effect to other behavioral health providers in Shelby County if the proposed addition of 14 beds is approved. Between 2014 and 2016, JAR data indicated that patient days of psychiatric care provided by service area facilities increased from 211,255 to 266,916. This is a two year increase of 15,661 patient days. The addition of 14 beds could have positive effects such as the reduction of wait times in the Emergency Department for children (10 and older), adolescents and adults requiring inpatient psychiatric treatment. The addition of 14 inpatient psychiatric beds could have further positive effects such as helping meet the growing needs of Medicare, TennCare/Medicaid, indigent and self-pay.

Letters of Support/Opposition

Letters of support for the applicant include: Alliance Healthcare Services, Youth Villages Specialized Crisis Services, National Alliance on Mental Illness (NAMI) Memphis, Professional Care Services of West TN, Quinco Mental Health Center, First Step Recovery Centers, Mark White (State Representative), Richard L. Hall (Germantown Chief of Police), Bellevue Baptist Church Counselling Ministry, Revelation of Hope Counseling Services, and Delta Medical Center. No letters of opposition have been received as of the date of review.

Contribution to the Orderly Development of Health Care

Working Relationship with Existing Providers

The applicant is currently licensed and has a working relationship with local crisis teams and health care providers in the area. This is further evidenced by the letters of support received for the certificate of need application.

Transfer Agreements

The applicant has medical transfer agreements with both Baptist Memorial Hospital and Saint Francis Hospital. The distance between Baptist Memorial Hospital and Crestwyn Behavioral Health is 14.0 miles. The distance between Saint Francis Hospital and Crestwyn Behavioral Health is 11.1 miles.

Training

Crestwyn Behavioral Health currently has clinical rotation agreements with Southwest Tennessee Community College, The University of Memphis, Rhodes University, Union University, and Christian Brothers University.

Conclusions

- Under the guideline of 30 beds per 100,000 persons, a surplus of beds to service the proposed service area is projected. Given that inpatient psychiatric services are necessary for the safety of the patient and/or the community, it would be prudent to have too many beds than too few. Crestwyn Behavioral Health provides a unique service as it provides inpatient mental health beds to the child/adolescent population.
- 2. The proposed project appears to be economically feasible. Costs for program development and budgeting appear reasonable and documentation supports the availability of needed capital for the addition of 14 beds.
- 3. The application for the addition of 14 inpatient mental health beds would contribute to the orderly development of health care in the state of Tennessee. Inpatient psychiatry services are reserved for circumstances in which no less restrictive alternative adequately provides for the safety of the patient or others, and are all the more necessary when so needed. The TDMHSAS is supportive of the intensive outpatient program provided to adolescents and adults, as it is an

essential piece of the continuum of care and can reduce the length of inpatient stay and decrease the need for highly restrictive inpatient services.

4. The proposed addition of 14 inpatient mental health beds would provide health care that meets appropriate quality standards. The applicant meets appropriate quality standards by possessing licensure from the TDMHSAS and accreditation by the Joint Commission. The proposed organizational structure, physical plant, and service delivery model are consistent with current standards.

TDMHSAS supports the addition of 14 inpatient mental health beds by Crestwyn Behavioral Health. Crestwyn Behavioral Health is accessible to individuals across the lifespan in need of inpatient psychiatric hospitalization, is accessible to low income and indigent patients, increases service availability, accepts involuntary admissions, and will serve TennCare and Medicare populations. The addition of 14 inpatient mental health beds will contribute to the availability of a continuum of psychiatric services by providing locally accessible inpatient mental health beds to individuals across the lifespan.

Laura Goung, DNP, APN, FPMHNP-BC

Laura Young, Chief Nursing Officer
Division of Hospital Services
TN Department of Mental Health and Substance Abuse Services
Andrew Jackson Building, 6th Floor
500 Deaderick Street
Nashville, Tennessee 37243